



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

July 8, 2019

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org; daniel.mcgrath@americanoversight.org

Dear Mr. McGrath:

This is the Sixth Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested: All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:
 - a. "Concerned Veterans"
 - b. "Concerned Vets"
 - c. CVA

d. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search.”

There is substantial overlap between FOIA request **18-11960-F** and your prior FOIA request **18-07426-F**, as there are responsive records responsive to both FOIA requests.

18-11960-F: 6th Partial IAD & Reasonable Searches Dated 12/19/18 & 5/2/19

On December 19, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below twelve (12) custodians from January 20, 2017, to December 19, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Byrne, Jim, current VA Acting Deputy Secretary;
- 5) Bowman, Thomas, former VA Deputy Secretary;
- 6) Powers, Pam, current VA Chief of Staff;
- 7) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 8) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 9) Selnick, Darin, former VA White House Senior Advisor;
- 10) Lukach, Michael, former VA White House Senior Advisor;
- 11) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 12) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On May 2, 2019, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms “Concerned Veterans of America,” “CVA,” “cv4a.org,” “CV4A,” “Concerned Vets,” and “Concerned Veterans” to search through the email boxes of the aforementioned twelve (12) custodians. Excluding the previous Clearwell search results for the First through Third Partial Initial Agency Decisions, this May 2, 2019, Clearwell search yielded approximately two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages.

Of the two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages, OSVA now releases thirty-two (32) emails and their attachments totaling six hundred forty-nine (649) pages, Bates-numbered 5129-5777. After reviewing the six hundred forty-nine (649) pages, OSVA redacts some information with FOIA Exemptions 5 and 6.

Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts portions of deliberations requiring press releases and Mission Act policies. The redacted information is both predecisional and deliberative because it reflects preliminary opinions and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the

withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

5 U.S.C. § 552(b)(6) exempts from required disclosure "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual's personal privacy without contributing significantly to the public's understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enf't, 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

Thus far, OSVA has released to you five thousand six hundred twenty-five (5,625) pages for FOIA requests **18-07426-F** and **18-11960-F**.

18-11960-F: 5/10/19, 5th Partial IAD

On May 10, 2019, after re-reconsidering OSVA's FOIA Exemption 5 redactions to pages Bates-numbered 1003-1005 and 1124-1132, OSVA no longer redacts them per FOIA Exemption 5.

On May 10, 2019, after re-considering OSVA's FOIA Exemption 5 redactions to a briefing memorandum and talking points (Bates-numbered 1030-1031), OSVA still believes those redactions are warranted. Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts portions of talking points and a briefing memorandum prepared for Secretary Shulkin for his meeting with Rep. Cathy McMorris-Rodgers. The redacted information is both predecisional and deliberative because it reflects preliminary opinions and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Access Reports v. DOJ, 926 F.2d 1192, 1196-97 (D.C. Cir. 1991) ("talking points" memoranda are predecisional); ACLU v. DHS, 738 F. Supp. 2d 93, 112 (D.D.C. 2010) ("talking points" are predecisional . . . the document itself suggests that a public statement was anticipated at the time of its creation, and given that no official statement has yet been made, the talking points remain ripe recommendations that are ready for adoption or rejection by the Department"); Sec. Fin. Life Ins. Co., No. 03-102-SBC, 2005 WL 839543, at *11 (D.D.C. Apr. 12, 2005) ("The undisputed evidence establishes that these [talking points] are deliberative"); Judicial Watch, Inc. v. U.S. Dep't of Commerce, 337 F. Supp. 2d 146, 174 (D.D.C. 2004) (protecting "talking points" and recommendations on how to answer questions); St. Louis Sewer Dist., No. 10-2103, at *18 (E.D. Mo. Mar. 2, 2012) (protecting e-mail communications, "press releases, talking points and 'Q & A,' drafts, and briefing materials"); Citizens for Responsibility & Ethics in Wash. v. DHS, 514 F. Supp. 2d 36, 44 (D.D.C. 2007) (protecting briefing materials concerning Hurricane Katrina response including proposed "solutions and approaches"); Judicial Watch, Inc. v. DOE, 310 F. Supp. 2d 271, 317 (D.D.C. 2004) (protecting briefing materials for Secretary of the Interior), aff'd in part, rev'd in part on other grounds & remanded, 412 F.3d 125, 133 (D.C. Cir. 2005); Klunzinger v. IRS, 27 F. Supp. 2d 1015, 1026 (W.D. 1998) (protecting paper to brief commissioner for meeting); Thompson v. Dep't of the Navy, No. 95-347, 1997 WL 527344, at *4 (D.D.C. Aug. 18, 1997) (protecting materials to brief senior officials responding to media inquiries, as "disclosure of materials reflecting the process by which the Navy formulates its policy concerning statements to and interactions with the press" could stifle frank communication within the agency), aff'd, No. 97-5292, 1998 WL 202253, at *1 (D.C. Cir. Mar. 11, 1998) (per curiam); Williams v. DOJ, 556 F. Supp. 63, 65 (D.D.C. 1982) (protecting "briefing papers prepared for the Attorney General prior to an appearance before a congressional committee").

18-11960-F: 5/8/19, 4th Partial IAD & Reasonable Searches Dated 12/19/18 & 5/2/19

From the aforementioned searches dated December 19, 2018, and May 2, 2019, yielding approximately two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages, OSVA released fourteen (14) emails and their attachments totaling five hundred seventy-four (574) pages, Bates-numbered as 4555-5128 on May 8, 2019. On

May 8, 2019, after reviewing the five hundred seventy-four (574) pages, OSVA redacted some information with FOIA Exemptions 5 and 6.

5 U.S.C. § 552(b)(5) exempts from required disclosure “inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency.” Under the attorney-client and work product privileges, the VA redacted portions of records, emails, and communications between VA employees and attorneys relating to federal lawsuits against the VA. The release of this information would impede the ability of VA employees and attorneys to speak openly and frankly about legal issues concerning lawsuits against the VA. The release of this information would also compromise the VA’s legal positions for its lawsuits.

18-11960-F: 5/2/19, 3rd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Bowman, Thomas, former VA Deputy Secretary;
- 5) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 6) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 7) Selnick, Darin, former VA White House Senior Advisor;
- 8) Lukach, Michael, former VA White House Senior Advisor;
- 9) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 10) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On September 11, 2018, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms “Concerned Veterans of America,” “CVA,” and “cv4a.org” to search the email boxes of: former VA Secretary David Shulkin, Robert Wilkie, Peter O'Rourke, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. This Clearwell search yielded one hundred eighty-two (182) documents totaling three thousand five hundred thirty-one (3,531) pages.

On November 30, 2018, OSVA released to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), redacted with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). On February 14, 2019, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, redacted with FOIA Exemptions 5 and 6.

18-11960-F: 2/14/19, 2nd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

From the aforementioned searches dated September 6, 2018, and September 11, 2018, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, on February 14, 2019, redacted with FOIA Exemptions 5 and 6.

18-11960-F: 11/30/18, Initial Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

Of the searches dated September 6, 2018, and September 11, 2018, OSVA released seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages on

November 30, 2018, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), on November 30, 2018.

After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacted some information with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). 5 U.S.C. § 552(b)(4) exempts from disclosure “trade secrets and commercial or financial information obtained from a person and privileged or confidential.” Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors’ technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting “descriptions of equipment and the names of contacts, customers, key employees, and subcontractors” because “bidders only submit such information if it will not be released to their competitors”); BDM Corp. v. SBA, 2 Gov’t Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which “could reasonably be expected to constitute an unwarranted invasion of personal privacy.” Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that “would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law.” Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

18-07426-F: 11/20/18, 2nd Partial IAD & Reasonable Searches Dated 5/8/18, 9/18/18, 10/12/18, 10/16/18, & 11/15/18

On October 12, 2018, and October 16, 2018, the OSVA FOIA office searched though former VA Acting Secretary Peter O’Rourke’s emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which the VA released redacted as pages Bates-numbered 243-286 on November 20, 2018.

On September 18, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd’s emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz,

@frenchangel59.com, and Kushner. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 on November 20, 2018.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: 1) Bowman, Thomas, former VA Deputy Secretary; 2) Wright-Simpson, Vivieca, former VA Chief of Staff; 3) Selnick, Darin, former VA White House Senior Advisor; 4) Lukach, Michael, former VA White House Senior Advisor; 5) Leinenkugel, Jake, former VA White House Senior Advisor; and 6) Spero, Casin D, former VA White House Liaison. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred seventy-two (272) pages, which OSVA released redacted as pages Bates-numbered 542-813 on November 20, 2018.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, including of:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) O'Rourke, Peter M., former VA Acting Secretary;
- 3) Bowman, Thomas, former VA Deputy Secretary;
- 4) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 5) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 6) Selnick, Darin, former VA White House Senior Advisor;
- 7) Lukach, Michael, former VA White House Senior Advisor;
- 8) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 9) Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA release redacted as pages Bates-numbered 814-815 on November 20, 2018.

Our May 8, 2018 (our search cut-off date) search yielded fifty-six (56) pages of email communication to or from Jared Kushner. On November 20, 2018, OSVA released these fifty-six (56) pages redacted as pages Bates-numbered 816-871.

After reviewing six hundred twenty-nine (629) pages Bates-numbered 243-871, OSVA redacted some information with FOIA Exemptions 4, 5, 6, and 7(C). Pages bates-numbered 872-995 are intentionally left blank.

18-07426-F: 9/14/18, Partial IAD & Reasonable Searches Dated 5/8/18

On May 8, 2018, our search cut-off date, we searched through former VA Secretary David Shulkin's emails and calendars from February 14, 2017 (the date he became VA Secretary), to March 30, 2018 (the date he left VA). We searched through VA Secretary Robert Wilkie's emails and calendars from April 1, 2018 (the date he became VA Acting Secretary) to May 8, 2018.

We searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from February 15, 2018 (the date he became VA Acting Chief of Staff), to May 3, 2018. VA will conduct a follow-up search of former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to May 8, 2018.

OSVA searched for any emails to or from Mr. Perlmutter, Dr. Moskowitz, and Mr. Kushner. Our search thus far yielded two hundred ninety-eight (298) pages, of which fifty-six (56) pages

require consultation with the White House FOIA Liaison. After reviewing two hundred forty-two (242) pages, OSVA redacted some information with FOIA Exemptions 5, 6, 7(C), and 7(E). Bates-numbered as 1-242 on September 14, 2018.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

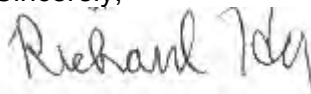
FOIA Appeal

This concludes OSVA's Sixth Partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,



Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachment - Redacted pages Bates-numbered 5129-5777

From: Connell, Lawrence B.
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=a3e7233376344045980ad2141223
(b) (6)>

To: (b) (6)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=6c7b029b060147faa7ef8b9f19a0
(b) (6)> Stone, Richard A., MD
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=bd16619615d64adea22e45e63ff6
(b) (6)>

Cc: Ulyot, John
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=c02392d86764480bb90e3854a5f3
(b) (6)> (b) (6) </o=exchangelabs/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=dba510634baa46a085e28c62c254
(b) (6)> Tucker, Brooks </o=exchangelabs/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=24ae47cff629405aa8557cc2cc79
(b) (6)> Syrek, Christopher D. (Chris)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=7699e816dfb941bf8048852495d7
(b) (6)> Powers, Pamela </o=exchangelabs/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=f6021d9c02594b52bc57194848ca
(b) (6)>

Bcc:

Subject: RE: CLC DC Walk Through

Date: Mon Nov 19 2018 20:49:35 CST

Attachments:

(b) (6)
Dr. Stone will not be in town during that time.

I will be

Sent with Good (www.good.com)

From: (b) (6)
Sent: Monday, November 19, 2018 3:22:42 PM
To: Stone, Richard A., MD; Connell, Lawrence B.
Cc: Ulyot, John; (b) (6) Tucker, Brooks; Syrek, Christopher D. (Chris); Powers, Pamela
Subject: RE: CLC DC Walk Through

All,

Brooks reminds me that Dr. Stone also invited the VSO's to walk a CLC together and offered up the DC 2 Star facility. (b) (6) will be in town from 13-15 December and is willing to schedule time for a walk through.

If this can work for our team I can begin to coordinate this effort.

Please let me know.

(b) (6)

From: (b) (6)
Sent: Monday, November 19, 2018 5:25 PM
To: Stone, Richard A., MD <Richard.Stone2@va.gov>; Connell, Lawrence B. <Lawrence.Connell@va.gov>
Cc: Ulliyot, John <John.Ulliyot@va.gov>; (b) (6) <(b) (6)@va.gov>; Tucker, Brooks <Brooks.Tucker@va.gov>; Syrek, Christopher D. (Chris) <Christopher.Syrek@va.gov>; Powers, Pamela <Pamela.Powers@va.gov>
Subject: CLC DC Walk Through

All,

Thank you for your support on today's phone call.

Participants included;

Enlisted Army National Guard US (EANGUS) Legislative and Government Affairs Director (b) (6)

DAV –

(b) (6)

PVA –

(b) (6)

& (b) (6)

AMVETS – Executive Director, (b) (6)

AMVETS – National Commander, (b) (6)

AMVEETS – (b) (6)

American Legion – Executive Director, (b) (6)

American Legion – National Commander, (b) (6)

VFW – Executive Director, (b) (6)

VFW – Comms, (b) (6)

VFW – (b) (6)

CVA – Executive Director, (b) (6)

WWP – Senior Vice President, Government & Community Relations, (b) (6)

Independence Fund – Chief Advocacy Officer, (b) (6)

Brief Overview/Summary of the phone call:

VSO CLC Call

Introduction: (b) (6) Dr. Stone

VFW, (b) (6) VSOs represented that they were not communicated to from the local PAOs, They feel they need a call when we at VA 'know a story is happening'

WWP; (b) (6) expounded on traditional communications and how we [VA] had done a good job with VBA and regularly meetings with Dr. Lawrence (*Side note, after the phone call (b) (6) raised the issue of tone and felt strongly that Dr. Stone was too 'heavy handed'). (b) (6) mentioned that she had previously spoken with (b) (6) about meetings and monthly meetings to avoid this type of communications 'misses.' (b) (6) also mentioned they were not party to the article and when asked to respond did not (of note, on Friday, November 16, 2018 (b) (6) WWP had asked for a heads up on the veracity of the story to share with their leadership).

AmVets – (b) (6) noted that communications synchronicity is about relationships and this story is like a Rorschach test – it's a matter of perspective and where the numbers convey one thing we still must improve from the anecdotal stories. He then asked about how Dr. Stone and VHA evaluate quality care in the community [outside the VA] and wanted to ensure that our (VHA) staffing sufficient?

VFW, (b) (6) Mentioned we need better communication needed and that VA should give them (VSOs) a heads up before the story goes to print.

Legion, (b) (6) Appreciated our communications and relationship and saw that as a solid way to avoid these types of incidents.

AMVETS: (b) (6) the National Commander mentioned that verbal communications are real important.

Send me!

(b) (6)

Senior Advisor, VSO Liaison Office of the Secretary

U.S. Department of Veterans Affairs

810 Vermont Avenue, NW

Washington, D.C. 20420

Desk: (202) 461- (b) (6)

Email: (b) (6) va.gov

From: (b) (6)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=6c7b029b060147faa7ef8b9f19a0
(b) (6)>

To: Stone, Richard A., MD
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=bd16619615d64adea22e45e63ff6
(b) (6)> Connell, Lawrence B.
</o=exchangelabs/ou=exchange administrative group
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(b) (6)>

Cc: Ulyot, John
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(b) (6)> Powers, Pamela </o=exchangelabs/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=f6021d9c02594b52bc57194848ca
(b) (6)>

Bcc:

Subject: RE: CLC DC Walk Through

Date: Mon Nov 19 2018 18:22:42 CST

Attachments:

All,

Brooks reminds me that Dr. Stone also invited the VSO's to walk a CLC together and offered up the DC 2 Star facility. (b) (6) will be in town from 13-15 December and is willing to schedule time for a walk through.

If this can work for our team I can begin to coordinate this effort.

Please let me know.

(b) (6)

From: (b) (6)
Sent: Monday, November 19, 2018 5:25 PM
To: Stone, Richard A., MD <Richard.Stone2@va.gov>; Connell, Lawrence B. <Lawrence.Connell@va.gov>
Cc: Ulliyot, John <John.Ulliyot@va.gov>; (b) (6) <(b) (6)@va.gov>; Tucker, Brooks <Brooks.Tucker@va.gov>; Syrek, Christopher D. (Chris) <Christopher.Syrek@va.gov>; Powers, Pamela <Pamela.Powers@va.gov>
Subject: CLC DC Walk Through

All,

Thank you for your support on today's phone call.

Participants included;

Enlisted Army National Guard US (EANGUS) Legislative and Government Affairs Director (b) (6)

DAV – (b) (6)

PVA – (b) (6) & (b) (6)

AMVETS – Executive Director, (b) (6)

AMVETS – National Commander, (b) (6)

AMVEETS – (b) (6)

American Legion – Executive Director, (b) (6)

American Legion – National Commander, (b) (6)

VFW – Executive Director, (b) (6)

VFW – Comms, (b) (6)

VFW – (b) (6)

CVA – Executive Director, (b) (6)

WWP – Senior Vice President, Government & Community Relations, (b) (6)

Independence Fund – Chief Advocacy Officer, (b) (6)

Brief Overview/Summary of the phone call:

VSO CLC Call

Introduction: (b) (6) Dr. Stone

VFW, (b) (6) VSOs represented that they were not communicated to from the local PAOs, They feel they need a call when we at VA 'know a story is happening'

WWP; (b) (6) expounded on traditional communications and how we [VA] had done a good job with VBA and regularly meetings with Dr. Lawrence (*Side note, after the phone call (b) (6) raised the issue of tone and felt strongly that Dr. Stone was too 'heavy handed'). (b) (6) mentioned that she had previously spoken with (b) (6) about meetings and monthly meetings to avoid this type of communications 'misses.' (b) (6) also mentioned they were not party to the article and when asked to respond did not (of note, on Friday, November 16, 2018 (b) (6) WWP had asked for a heads up on the veracity of the story to share with their leadership).

AmVets – (b) (6) noted that communications synchronicity is about relationships and this story is like a Rorschach test – it's a matter of perspective and where the numbers convey one thing we still must improve from the anecdotal stories. He then asked about how Dr. Stone and VHA evaluate quality care in the community [outside the VA] and wanted to ensure that our (VHA) staffing sufficient?

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Legion, (b) (6) Appreciated our communications and relationship and saw that as a solid way to avoid these types of incidents.

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Send me!

(b) (6)

Senior Advisor, VSO Liaison Office of the Secretary

U.S. Department of Veterans Affairs

810 Vermont Avenue, NW

Washington, D.C. 20420

Desk: (202) 461-(b) (6)

Email: (b) (6) va.gov

From: (b) (6)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=6c7b029b060147faa7ef8b9f19a0
(b) (6)

To: Stone, Richard A., MD
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=bd16619615d64adea22e45e63ff6
(b) (6) Connell, Lawrence B.
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Cc: Ulliyot, John
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(fydibohf23spdlt)/cn=recipients/cn=7699e816dfb941bf8048852495d7
(b) (6) Powers, Pamela </o=exchangelabs/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=f6021d9c02594b52bc57194848ca
(b) (6)

Bcc:

Subject: CLC DC Walk Through

Date: Mon Nov 19 2018 17:24:41 CST

Attachments:

All,

Thank you for your support on today's phone call.

Participants included;

Enlisted Army National Guard US (EANGUS) Legislative and Government Affairs Director) (b) (6)

DAV – (b) (6) (b) (6)

PVA – (b) (6) & (b) (6)

AMVETS – Executive Director, (b) (6)

AMVETS – National Commander, (b) (6)

AMVEETS – (b) (6)

American Legion – Executive Director, (b) (6)

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VFW – Executive Director, (b) (6)

VFW – Comms, (b) (6)

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810 Vermont Avenue, NW

Washington, D.C. 20420

Desk: (202) 461- (b) (6)

Email: (b) (6) va.gov

From: Syrek, Christopher D. (Chris)
</o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=7699e816dfb941bf8048852495d7
(b) (6)>

To: Powers, Pamela
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(b) (6)>

Bcc:

Subject: Thursday Event Memo

Date: Tue Nov 13 2018 18:04:06 CST

Attachments: Copy of Attendees with Titles 11-9.xlsx
Event Memo - Supporting Veterans and Military Families through the State...v1_3 -
Hold.docx

Pam,

Final event memo for Thursday with list of attendees.

+ (b) (6) to include as a read ahead for SECVA before tomorrow's briefing.

+ (b) (6) and (b) (6) – you can add this to Pam and my books.

Thanks!

Christopher D. Syrek

Deputy Chief of Staff

U.S. Department of Veterans Affairs

Washington, D.C. 20420 | (202) 461-7486

Owner: Syrek, Christopher D. (Chris) </o=exchangelabs/ou=exchange administrative group
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Filename: Copy of Attendees with Titles 11-9.xlsx
Last Modified: Tue Nov 13 17:04:06 CST 2018

Organization	Title
State of Alaska, Office of Veterans Affairs	Deputy Director
Student Veterans of America	Chapter Advisor
National Association of County Veteran Service Officers	
San Diego County Office	VSO
American Legion	Women and Minority Veterans Outreach Assistant Director
Concerned Veterans for America	
DC Office of Veterans Affairs	Director
Elizabeth Dole Foundation	Executive Director
General Assembly	Data Science Consultant
Military Order of the Purple Heart	National Legislative Director
Paralyzed Veterans of America	Associate Legislative Director
Republican Governors Public Policy Committee	Policy Advisor
US Department of Commerce	National Deputy Director
Veterans of Foreign War	Customer Support Claims Consultant
CNCN	Senior Advisor for Veterans, Military Fa
Florida State Legislature	Representative
Georgia Department of Human Services	Commissioner
Home Base Iowa	Project Manager
Iowa Workforce Development	Veterans Program Coordinator
Iowa Workforce Development	Director
Idaho Divisions of Veterans Affairs	Chief
Indiana Department of Veterans Affairs	State Veterans Leaders
Indiana Department of Veterans Affairs	Deputy Director
Kansas Department of Labor	Secretary
Kansas House of Representatives	Representative
Louisiana Workforce Commission	Secretary
Massachusetts National Guard	Adjutant General
American Legion	Deputy Director, Veterans Affairs and Rehabilitation Division
American Legion	Assistant Director, Veterans Employment and Education Division Staff
Arkansas Department of Veterans Affairs	Director
Cecil County Chapter 703 - Military Order of the Purple Heart	Commander
Disabled American Veterans	National Service Director
Maryland Department of Budget and Management	Local Veterans Employment Representa
Maryland Department of Veterans Affairs	Deputy Secretary
Maryland Department of Veterans Affairs	Director, Service and Benefits Program

NASWA	Executive Director
National Association of Workforce Boards	Membership Associate
Office of Governor Larry Hogan	State Federal Representative
Paralyzed Veterans of America	Executive Director
Veterans of Foreign War	Assistant Director, Compensation and Pension Policy
Congresswoman Chellie Pingree	Veteran Constituent Services and Field Representative
Michigan Veterans Affairs Agency	Deputy Director
Department of Employment Security	Director
Harrison County Veterans Service Office	Judicial District 1
Valley Veterans Service Center	VSO
Valley Veterans Service Center	Director
National Association of County Veteran Service Officers	
City of Havelock, NC	Mayor
New Hampshire State Legislature	Representative
National Association of County Veteran Service Officers	Washington Liaison Chair
New Jersey Department of Military and Veterans Affairs	Deputy Commissioner
Ocean County Veteran Service Office	Director
Nevada Department of Veterans Services	Deputy Director of Programs and Services
New York State Senate	Senator
New York State Senate	Chief of Staff, Senator Terrence Murphy
New York State Senate	Senator
Ashland County Veterans Service Office	Veterans Service Officer
National Association of County Veteran Service Officers	President
National Association of County Veteran Service Officers	1st Vice President
National Association of County Veteran Service Officers	Immediate Past President
Van Wert County Veterans Service Office	Veterans Service Officer
Oklahoma Department of Veterans Affairs	Director
PA House of Representatives	Research Analyst
Pennsylvania Department of Military Affairs	Sergeant Major
Pennsylvania House of Representatives	Representative
Pennsylvania Military & Veterans Affairs	Director, Bureau of Veterans Programs,
Only attending Tour	
Only attending Tour	
Only attending Tour	
Department of Employment and Workforce	Director
Lancaster County Veterans Affairs Office	Director
Project Josiah	Executive Director
SC Thrive	Executive Director

SCACVAO	Veterans Affairs Officer
SCACVAO	
SCACVAO	Veterans Affairs Officer
South Carolina Association of County Veterans Affairs Officers	President
Belvoir Spouses Club	
City of Killeen, TX	Mayor
Health and Human	Senior Policy Advisor
National Association of County Veteran Service Officers	
National Association of County Veteran Service Officers	
National Association of County Veteran Service Officers	
Texas Health and Human Services Commission	Program Director for Veterans Services
Texas Workforce Commission	Division Director
Texas Workforce Commission	Attorney and Policy Advisor
Utah Attorney General's Office	Attorney General
Utah House of Representatives	Representative
American Legion	Legislative Assistant Director
Americans for Prosperity	Government Relations
Blue Star Families	Mrs.
Blue Star Families	
Blue Star Families	CEO and Board President
Daughters of the American Revolution	National Legislative Director
Department of Veterans Affairs	Tribal Relations
	Chief of Staff, Office of Public and Intergovernmental Affairs
Department of Veterans Affairs	Deputy Chief of Staff
Kings George County	Legislative Assistant
National Military Family Association	Government Relations Director
National Military Mily Association	Government Relations Deputy Director
	Associate Executive Director of Government Relations
Paralyzed Veterans of America	Deputy Executive Director
Paralyzed Veterans of America	
Paralyzed Veterans of America	Associate Executive Director of Veterans Benefits
Student Veterans of America	Executive Director
Veterans of Foreign War	Veterans Casework Consultant
Virginia Department of Veterans Services	Staff of DVS Benefits Director
Virginia House of Delegates	Delegate
Vriginia Department of Veterans and Defense Affairs	Secretary
West Virginia House of Delegates	Representative
	Mrs.

	Veterans Chair
	Mr.
Department of Human Services	Secretary
King County, WA	Councilmember
National Association of County Veteran Service Officers	
Wisconsin Army National Guard	International Partnership Specialist
Wisconsin Veterans Affairs	Talent Initiatives Director
Wisconsin Veterans Affairs	State Field Representative
American Foundation for Suicide Prevention	Senior Vice President

First Name	Last Name	Contact Email	CITY	State
(b) (6)		@alaska.gov	Wasilla	AK
(b) (6)		@unlv.nevada.edu	Anchorage	AK
(b) (6)				
(b) (6)		@hwave.com	HuntingtonBeach	CA
(b) (6)		@sdcounty.ca.gov	SanDiego	CA
(b) (6)				
(b) (6)		@legion.org	DistrictofColumbia	DC
(b) (6)		@cv4a.org	Washington	DC
(b) (6)		@dc.gov	Washington	DC
(b) (6)		@gmail.com	Washington	DC
(b) (6)		@gmail.com	Washington	DC
(b) (6)		(b) (6) purpleheart.org	Washington	DC
(b) (6)		(b) (6) @pva.org	Washington	DC
(b) (6)		@gmail.com	Washington	DC
(b) (6)		(b) (6) chrisgarcia.us	Washington	DC
(b) (6)				
(b) (6)		@vfw.org	Washington	DC
(b) (6)		@cns.gov	Pensacola	FL
(b) (6)		@myfloridahouse.gov	Zephyrhills	FL
(b) (6)		@dhs.ga.gov	Marietta	GA
(b) (6)		iwd.iowa.gov	Clive	IA
(b) (6)		@iwd.iowa.gov	Ankeny	IA
(b) (6)		@iwd.iowa.gov	Granger	IA
(b) (6)		@veterans.idaho.gov	Meridian	ID
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(b) (6)		@dva.in.gov	indianapolis	IN
(b) (6)		@ks.gov	Topeka	KS
(b) (6)		yahoo.com	Lawrence	KS
(b) (6)		@lwc.la.gov	BatonRouge	LA
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(b) (6)				
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(b) (6)		@dav.org	ChesapeakeBeach	MD
(b) (6)		@gmail.com	Randallstown	MD
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(b) (6)				
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(b) (6)			@gmail.com	Hamilton	MT
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(b) (6)			@pa.gov	Lebanon	PA
(b) (6)			@pahousegop.com	Lebanon	PA
(b) (6)			@pa.gov	Manheim	PA
(b) (6)			@yahoo.com	Lancaster	SC
(b) (6)			@lancastercountysc.net	Lancaster	SC
(b) (6)				Lancaster	SC
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(b) (6)			@lancastercountysc.net	Lancaster	SC
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(b) (6)			@scthrive.org	Columbia	SC

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(b) (6)		@gmail.com	PARKCITY	UT
(b) (6)		@legion.org	Fairfax	VA
(b) (6)		@afphq.org	Arlington	VA
(b) (6)		@bluestarfam.org	Alexandria	VA
(b) (6)		@bluestarfam.org	Alexandria	VA
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(b) (6)		@dav.org	Alexandria	VA
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Christopher	Syrek	christopher.syrek@va.gov	Alexandria	VA
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(b) (6)		@militaryfamily.org	Annandale	VA
(b) (6)				
(b) (6)		@militaryfamily.org	Alexandria	VA
(b) (6)				
(b) (6)		@pva.org	Arlington	VA
(b) (6)		@pva.org	Alexandria	VA
(b) (6)				
(b) (6)		@pva.org	BroadRun	VA
(b) (5)		studentveterans.org	Alexandria	VA
(b) (6)	(b) (6)	vfw.org	Alexandria	VA
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(b) (6)			@mail.mil	Edgerton	WI
(b) (6)			@wedc.org	GreenBay	WI
(b) (6)			@dva.wisconsin.gov	Westfield	WI
(b) (6)			@afsp.org	HarpersFerry	WV

Owner: Syrek, Christopher D. (Chris) </o=exchangelabs/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=7699e816dfb941bf8048852495d7c4c9-[REDACTED]
Filename: Event Memo - Supporting Veterans and Military Families through the State...v1_3 -
Hold.docx
Last Modified: Tue Nov 13 17:04:06 CST 2018

THE WHITE HOUSE
WASHINGTON

SUPPORTING VETERANS AND MILITARY FAMILIES

WHEN: Thursday, November 15, 2018
12:30 p.m. – 6:00 p.m.

LOCATION: Eisenhower Executive Office Building, South Court Auditorium

FORMAT: Conference

PRESS PLAN: POOL SPRAY

ATTIRE: Business

PROJECT OFFICER: (b) (6), (b) (7)(C), Assistant to the President & Counselor
(b) (6), (b) (7)(C), Deputy Assistant to the President & Director of Intergovernmental Affairs (IGA)

EXTERNAL PARTICIPANTS:

Attorney General Sean Reyes (R, UT)
State Veterans Affairs Leaders
State Adjutants General
State Workforce Development Leaders
State Human Services and Mental Health Leaders
State Legislators
County Veterans Affairs Leaders
County Commissioners
Tribal Veterans Affairs Leaders
Veterans' Service Organizations (American Legion, Veterans of Foreign Wars, Blue Star Families, Paralyzed Veterans of America, etc.)

**See Appendix I for Complete List of Attendees*

INTERNAL PARTICIPANTS:

Secretary Alex Acosta, U.S. Department of Labor
Secretary Robert Wilkie, U.S. Department of Veterans Affairs
(b) (6), (b) (7)(C), Assistant to the President & Director of the Domestic Policy Council
(b) (6), (b) (7)(C), Deputy Assistant to the President & Director, IGA
(b) (6), (b) (7)(C), Deputy Assistant to the President for Domestic Policy & Deputy Director of the Domestic Policy Council (DPC)
(b) (6), (b) (7)(C), Special Assistant to the President & Deputy Director, IGA

(b) (6), (b) (7)(C), Special Assistant to the President & Deputy Director, IGA

(b) (6), (b) (7)(C), Special Assistant to the President & Deputy Director, White House Office of Public Liaison

(b) (6), (b) (7)(C) Special Assistant to the President, DPC

John Ullyot, Assistant Secretary for Public and Intergovernmental Affairs, U.S. Department of Veterans Affairs (VA)

(b) (6), (b) (7)(C), Deputy Assistant Secretary of Defense, Force Education and Training, U.S. Department of Defense

Matt Miller, Deputy Assistant Secretary for Policy, Veterans' Employment and Training Service, U.S. Department of Labor

Margarita Devlin, Principal Deputy Under Secretary for Benefits, VA

EVENT BACKGROUND:

The President is committed to the ongoing care and support of our Veterans and their families. State and local governments play a vital role in helping achieve the shared goal of supporting our Veterans and military families – from improved health care to transitions in post-military employment to reducing Veterans' homelessness. The President will give remarks as part of a conference with State and local Veterans leaders to highlight the Trump Administration's accomplishments in supporting Veterans and military families and identify opportunities to further support our nation's Veterans in partnership. In May, President Trump signed an Executive Order enhancing opportunity for military spouses looking for employment in the Federal Government. Additionally, the President has taken many actions to support Veterans through improved healthcare services like telehealth and workforce training for returning Veterans, and homeless Veteran's reintegration. The President has made rebuilding our military one of his top priorities. The March 2018 omnibus spending bill also funded the VA at \$81.5 billion, including an additional \$2 billion for infrastructure programs to repair and enhance VA medical facilities and State Veterans Homes. In August, President Trump signed the NDAA authorizing \$716 billion for our national defense including a 2.6% military pay raise.

In 2017, White House IGA hosted a similar conference with Cabinet Members and State and local Veterans leaders to build relationships and identify opportunities to better serve Veterans and military families in partnership.

SEQUENCE OF EVENTS:

- 10:30 a.m. *Press pre-set for the President's Remarks*
- 12:30 p.m. (b) (6), (b) (7)(C) Provides Welcoming Remarks
- 12:32 p.m. Recorded Video of Second Lady Karen Pence's Remarks
- 12:38 p.m. John Ullyot Introduces Secretary Robert Wilkie
- 12:40 p.m. Secretary Wilkie Makes Remarks

12:55 p.m. Secretary Wilkie Q&A

1:10 p.m. Matt Miller Introduces Secretary Alex Acosta

1:12 p.m. Secretary Acosta Makes Remarks

1:29 p.m. Secretary Acosta Concludes Remarks and Remains on Stage

1:30 p.m. HOLD

1:31 p.m. HOLD

1:45 p.m. Federal Leaders Panel Discussion on Military Families
Moderator: (b) (6), (b) (7)(C), Special Assistant to the President and Deputy Director, White House Office of Public Liaison (Confirmed)
(b) (6), (b) (7)(C) Domestic Policy Council (Confirmed)
Matt Miller, Deputy Assistant Secretary, Department of Labor (Confirmed)

2:20 p.m. (b) (6), (b) (7)(C) Provides Breakout Session Overview

2:25 p.m. Movement to Breakout Session

2:40 p.m. Breakout Session 1

3:30 p.m. Transition

3:45 p.m. Breakout Session 2

4:30 p.m. Transition Attendees to 430ABC for Reception, or Exit

4:45 p.m. Reception begins in Room 430ABC

6:00 p.m. Reception ends

Breakout Topics:

1. Supporting Military Families (Cordell Hull 208)

Discussing Employment, Education, and Licensure for Military Spouse and Families

Department of Defense

(b) (6), (b) (7)(C), Director, Defense-State Liaison, Military Community and Family Policy (confirmed)

Department of Labor

Patti Greene, Director, Women's Bureau (Confirmed)

Daniel Greenberg, Senior Policy Advisor to the Secretary, DOL (Confirmed)

White House

Moderator: (b) (6), (b) (7)(C), White House Fellow, Office of the Vice President (Confirmed)

(b) (6), (b) (7)(C), White House Fellow, Office of the Vice President (Confirmed)

2. **Veteran Job Training and Re-Skilling (430ABC)**

Discussing Workforce Development and Education for Our Veterans

Department of Labor

Moderator: Matt Miller, Deputy Assistant Secretary for Policy, Veterans' Employment and Training Service (Confirmed)

Ivan Denton, Director of National Programs (Confirmed)

Department of Defense

— (b) (6), (b) (7)(C), Special Assistant, Office of the Under Secretary of Defense (Confirmed)

— (b) (6), (b) (7)(C), Deputy Assistant Secretary of Defense, Force Education and Training (Confirmed)

— Dr. (b) (6), (b) (7)(C), Director, Transition to Veterans Program Office (Confirmed)

Veterans Affairs

Josh Quill, Acting Chief of Staff, Veterans Benefits Administration (Confirmed)

3. **Preventing Veterans Suicide (South Court Auditorium)**

Discussing Veterans Mental Health Needs and Suicide Prevention

Veterans Affairs

Dr. David Carroll, Executive Director, Mental Health and Suicide Prevention, Veterans Health Administration

(b) (6), Deputy Director, Partnerships, Suicide Prevention Program, Veterans Health Administration

White House

Moderator: (b) (6), (b) (7)(C) Special Assistant to the President for Domestic Policy (Confirmed)

Health and Human Services

Meena Vythilingam, Senior Mental Health Advisor, Office of the Assistant Secretary for Health (Confirmed)

ATTACHMENTS:

Appendix I – List of Attendees (Names, Titles)

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Veterans Service Organization Communicators Meeting Agenda (7 November).docx

Good afternoon,

I have attached the agenda for next Wednesday's meeting here. Please note that we are starting the meeting fifteen minutes earlier than the last one, at 10:45 AM, and allow time for security. I look forward to seeing all of you next week. As always, feel free to contact me if you have any questions.

Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

Explore VA today! <http://explore.va.gov/>

LVA Class of 2017

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Veterans Service Organization Communicators Meeting **7 November, 2018**

Agenda

10:25 - 10:45: Security

10:45 – 10:50: Opening Remarks

10:50 - 11:40: Briefings

- **10:50 – 11:10: Office of Community Care Contracts update**
- **11:10 – 11:30: Office of Transition and Economic Development**
- **11:30 – 11:40: NCA update**

11:40 - Feedback from VSOs/MSOs

Closing Comments: OPIA

Next meeting:

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Bcc:
Subject: VA Operations Board (VAOB) Meeting
Date: Tue Oct 30 2018 17:33:13 CDT
Attachments: 181113 VAOB Final.pptx

StartTime: Tue Nov 13 09:00:00 Central Standard Time 2018
EndTime: Tue Nov 13 11:00:00 Central Standard Time 2018
Location: Omar Bradley Conference Room (OBCR)
Invitees: VA OB Members
Recurring: No
ShowReminder: No
Accepted: Yes
AcceptedTime: Mon Nov 05 09:46:00 Central Standard Time 2018

Good Evening, please accept our apologies for the delay with the attachments.

Copies will be provided at the meeting. We sincerely thank you for your patience and flexibility.

Chair: Acting Deputy Secretary, Mr. Jim Byrne

Principal Attendees: Assistant Secretaries, Under Secretaries and Key Officials

Purpose: The VAOB has bi-monthly meetings every 2nd and 4th Monday. The 2nd Monday meeting focuses on management issues (i.e., CXO updates, Congressionally Mandated/Tracked Reports, and Executive Correspondence). The 4th Monday meeting focuses on budget execution and performance.

Due to the holiday on Monday, November 12th (Veteran's Day), this meeting is rescheduled to Tuesday, November 13th.

Read ahead materials will be provided NLT two business days prior to the scheduled meeting. If your organization's POCs require updating, do not hesitate to contact EGM with these changes.

If you have any questions, please do not hesitate to contact Ms. (b) (6) at 202-266-(b) (6) or (b) (6) va.gov, or the Enterprise Governance Management (EGM) Team at EGMTeam@va.

gov. Thank you and have a great day.

Sincerely,

EGM Team

Owner: VA Governance Secretariat </o=exchangelabs/ou=exchange administrative group
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VA Operations Board Meeting

November 13, 2018
Omar Bradley Conference Room

Agenda

Item #	Topic	Briefer
1	Opening Comments	Mr. Jim Byrne, Acting Deputy Secretary of Veterans Affairs
2	Introduction	Dr. Melissa Glynn, Assistant Secretary for Enterprise Integration
3	Recurring Updates a. Congressionally Mandated Reports b. Executive Correspondence	Mr. Brooks Tucker, Assistant Secretary for Congressional and Legislative Affairs Mr. (b) (6) Office of the Executive Secretariat
4	CXO Updates	
	a. Chief Financial Officer	Mr. Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer
	b. Chief Information Officer	Mr. Camilo Sandoval, Executive-in-Charge, Office of Information and Technology
	c. Chief Acquisition Officer	Ms. Karen Brazell, Principal Executive Director and Chief Acquisition Officer, Office of Acquisition, Logistics and Construction
	d. Customer Experience Officer	Dr. Lynda Davis, Chief Veterans Experience Officer
	e. Chief Human Capital Officer	Ms. Jacquelyn Hayes-Byrd, Acting Assistant Secretary for Human Resources and Administration

Agenda

Item #	Topic	Briefer
5	Management Deep Dive – Manpower Standards and Approach and Approach to Calculating Current Vacancies and Manpower	Ms. Carin Otero, Deputy Assistant Secretary, Office of Human Resources Management
6	Management Deep Dive – OAWP Policies and Operations	Mr. Kirk Nicholas, Executive Director, Office of Accountability and Whistleblower Protection
7	Management Deep Dive – IT UFR Process and Current Integrated Priority List	Mr. Camilo Sandoval, Executive-in-Charge, Office of Information and Technology
8	Management Deep Dive – VA Operational Planning	Mr. John Basso, Deputy Assistant Secretary, Planning and Performance Management, Office of Enterprise Integration
9	Upcoming VA Operations Board Meetings a. November 26 – Budget Execution and Performance Review b. December 10 – Management Issues	Mr. Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer Dr. Melissa Glynn, Assistant Secretary for Enterprise Integration
10	Closing Remarks and Actions	Mr. Jim Byrne, Acting Deputy Secretary for Veterans Affairs

VAOB Action Item Tracker

#	Action Item	Owner(s) (Lead/Support)	Due Date (or weekly default)	Status/Notes (Include anticipated/completion dates)	Next Steps, if any, after completion of Action Item
1	Provide Mr. Dat Tran and Mr. John Basso with Management issues that your organization would like to see reviewed in the VAOB	ALL	Ongoing	Ongoing.	
2	Meet with OIT to align VA & OIT Governance Boards	OEI	11/20	Ongoing. Preliminary meetings held with OEI and OIT. Additional meetings are being scheduled.	
3	Provide a list of proposed Customer Service Performance Measures for SES Performance Plans	OEI VEO	11/20	Memo dated 10/26/18 in VIEWS for comments.	
4	Every Office must provide updates to their Operational and Strategic Performance measures to OEI's Director of Performance, (b) (6) (b) (6) va.gov)	All	11/20	Ongoing. OEI has met with all organizations. Awaiting final measures and data.	
5	Review the list of Congressional Reports and identify which report should be moved to the 'Unnecessary Report List'. Send updates to OEI's Director of Performance, (b) (6) (b) (6) va.gov)	All	11/20	Ongoing. See Back Up slides.	
6	Provide a list of OGC POCs to address various legal issues within the agency	OGC	11/19	Completed. See Back Up slides.	None

Recurring Updates

Office of Congressional and Legislative Affairs

Congressionally Mandated Reports

Congressionally Mandated Reports

PAST DUE as of November 5, 2018

14 Congressionally Mandated Reports (CMRs) for FY18 (1 with ExecSec/OSVA for SECVA signature):

VHA: 9	(oldest 249 days overdue)
OALC: 1	(98 days overdue)
HRA: 1	(85 days overdue)
OIT: 2	(oldest 81 days overdue)
VBA: 1	(61 days overdue)

7 CMRs for FY19

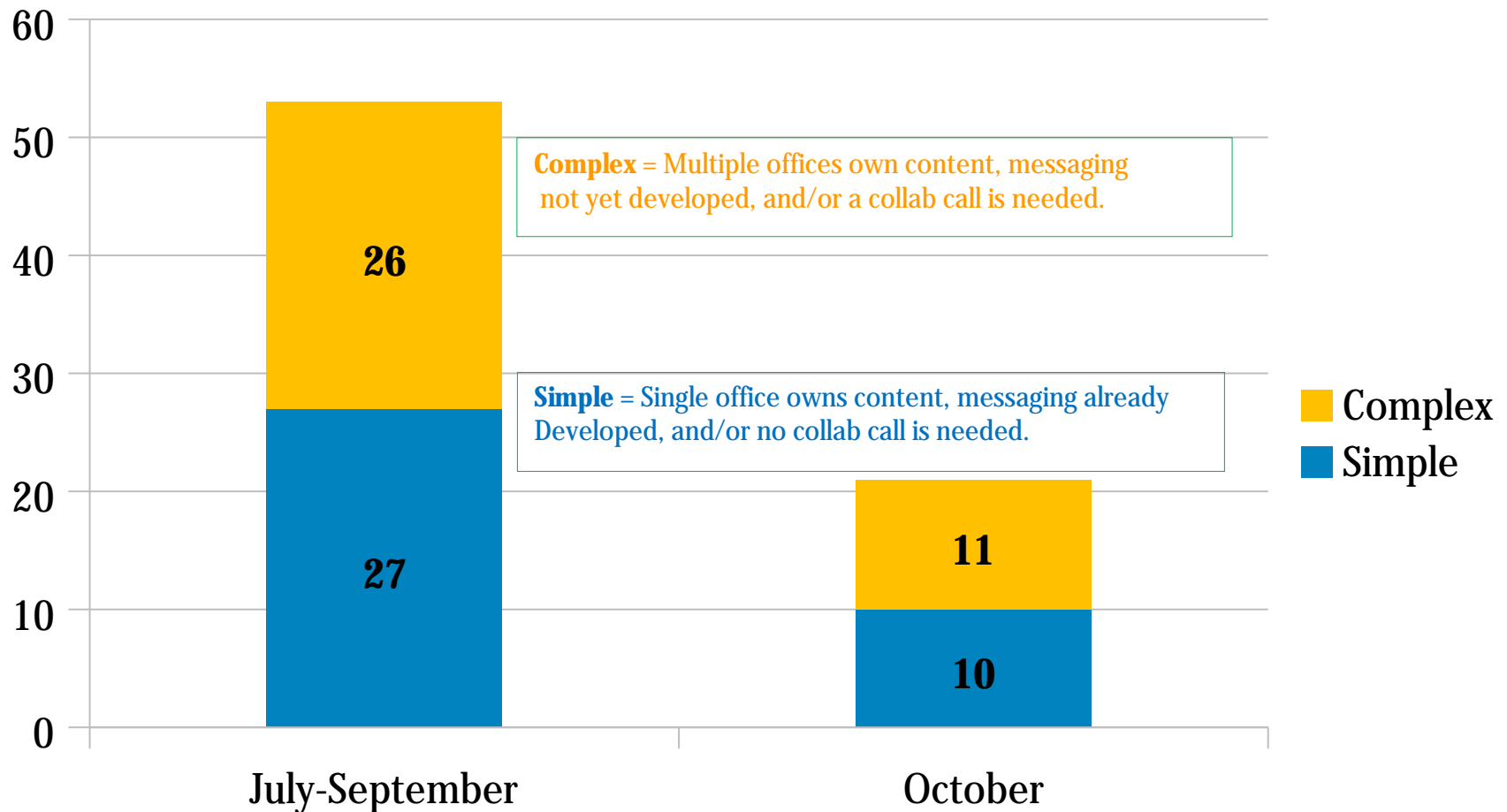
FYI

VIEWS letter for November 13, 2019 HVAC Health Hearing cleared OMB on November 2, 2018 with ExecSec for signature (two bills; hearing notice was very late; therefore, no opportunity was provided for a written testimony to be submitted).

Office of the Executive Secretary (EXECSEC)

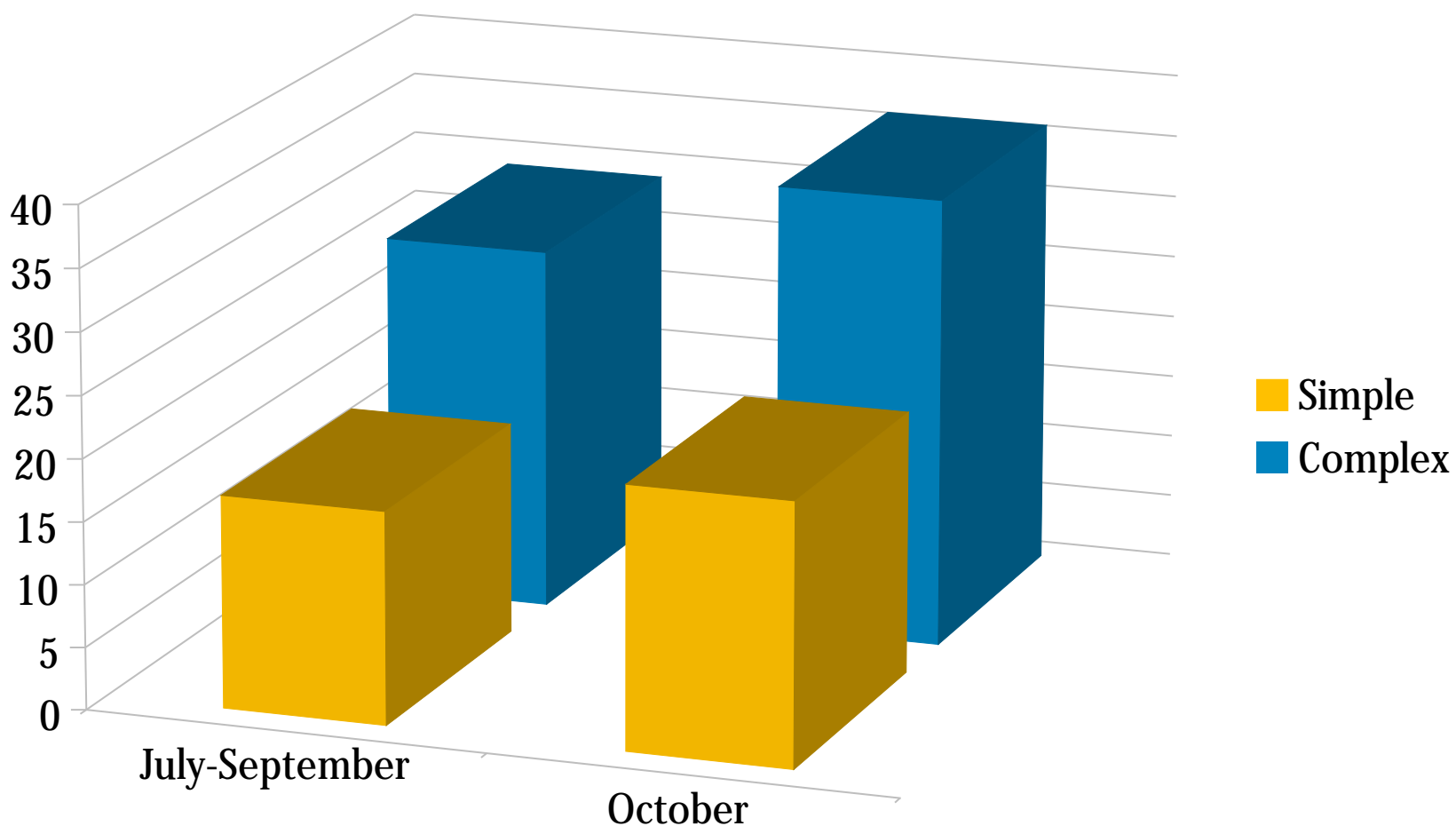
Congressional Responses Update

EXECSEC Congressional Responses Completed

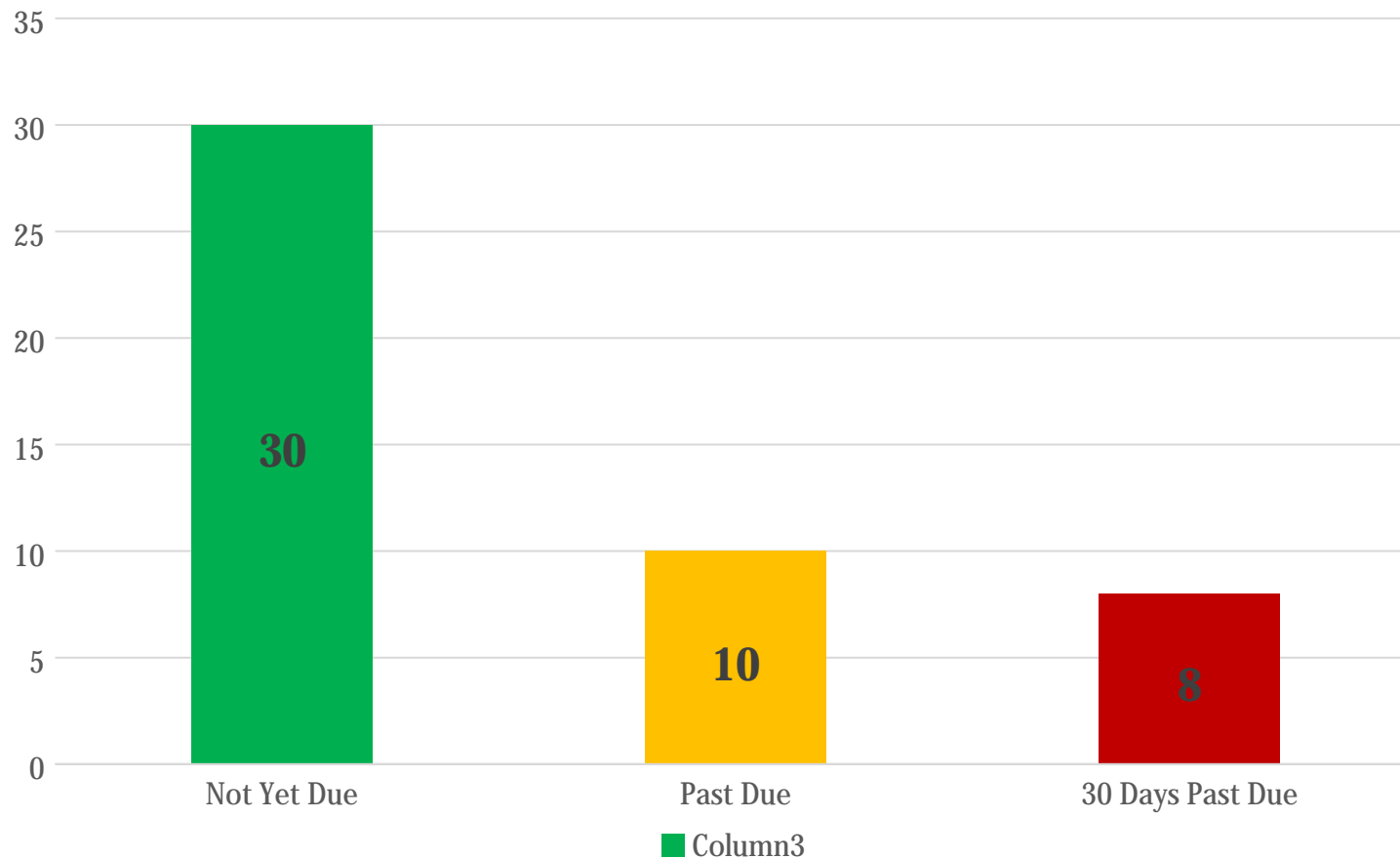


EXECSEC Congressional Responses - Average Days by Category

Average Days – Receipt to Signature Simple and Complex



EXECSEC Congressional Letters In-Work – As of November 9, 2018



CXO Updates

Chief Financial Officer

Overview

Purpose: Advise VA CFO on matters related to VA's overall financial management:

Collaborate to ensure financial priorities are consistent with VA's strategic goals and objectives.

Vet changes related to VA Financial Policy.

Last Session: November 1, 2018

New Focus: Deep Dive Sessions based on Council's preference

Updates

VA CFO Council Updates:

Deep Dive Topic: VA Reimbursables

Identified ways to improve overall accountability and timeliness of reimbursable funding agreements.

Realigned select reimbursements to Franchise Fund/BA.

Establishing Quarterly forum for customers/service providers.

Next Deep Dives:

VA Vacancies - HRSmart data

PIV Program Reimbursables

Chief Financial Officer

Primary Policies and Directives

Financial Policy Approvals: (five-year updates)
 Volume I, Chapter 5 – Management Accountability and Responsibility for Internal Controls.
 Volume II, Chapter 9 – Prior-Year Recovery.

Cancelled: VA's Travel Savings Award program
 Implementation costs exceed travel saving benefits.
 FY17: VA spent \$227M to save \$25K.

Risks

FY18 VA Financial Statement Audit:

End of Audit Meetings:
 November 6, 2018 – Meeting with Clifton Larson Allen (CLA), OIG, and CFO stakeholders.
 November 7, 2018 – Meeting with CLA, OIG, and SECVA.

Developing Corrective Action Plans (CAPs) for audit findings:
 Initiating Financial Integrity Team (FIT) Program to support and lead proactive audit remediation.

Chief Information Officer

Overview

IT Governance Oversight Board (ITGB)-October 24, 2018

OIT Councils Supporting ITGB:

Program & Acquisition Review Council (PARC) met October 16, 2018.

Standards & Architecture Council (SAC) met October 22, 2018.

Organization & Workforce Council (OWC) met October 18, 2018.

Updates

IT Governance Oversight Board (ITGB) – October 24, 2018 (Next Meeting: December 2018):

PARC will research industry best practices and brief on incorporation of Cloud/Dev-Ops into the IT Governance Framework.

Analytics and Performance Management Committee (APMC) will develop specific CIO Governance Metrics for monthly review.

Standards and Architecture Council (SAC) – October 22, 2018:

Approved Enterprise Cybersecurity Strategy Program (ECSP) accountability plan for each Pillar.

Program and Acquisition Review Council (PARC) – October 16, 2018:

APMC to monitor major investments for risks, if risks are found, APMC will report to the Operations and Portfolio committee (OPMC) with recommendations for a TechSTAT Review. Budget, Planning and Acquisition Committee (BPAC) to perform an assessment of the Acquisition Review Module (ARM) threshold limits/ARM processes and provide recommendation on improving the tools acquisition tracking methods.

Chief Information Officer

Primary Policies and Directives

Key external policies guiding the Governance Oversight Board: Executive Order 13833: Enhancing the Effectiveness of Agency Chief Information Officers, FITARA, Clinger-Cohen Act of 1996, OMB Circular A-130, FISMA of 2014, Federal Managers' Financial Integrity Act (FMFIA), the Government Performance and Results Act Modernization Act of 2010 (GPRAMA), and National Institute of Standards and Technologies (NIST) Standards.

Working with OSP to address the Executive Order on Cyber Workforce.

Risks

Working through DoD/VA MedCOI MOU.
Working with VBA to address key issues on Colmery Act Sections Implementation.
Working to develop VHA's final 10 detailed business epics, which are delaying IT work on MISSION Act--three requirements are in progress. Working with OEI to accelerate Section 211 requirements.

Chief Acquisition Officer

Authority: Sec. 16A of the Office of Federal Procurement Policy (OFPP) Act, as amended, 41 U.S.C. 403, et seq.

Overview

Serves as principal interagency forum for monitoring and improving Federal acquisition system. Chaired by OMB's Deputy Director for Management; Vice-Chair selected by Council from among members; Members: Agency CAOs, Under Secretary of Defense for Acquisition, Logistics and Technology, and Senior Procurement Executives of each military department. The OFPP Administrator leads the Council on behalf of the Chair; administrative support is provided by GSA.

Meets every 3 months with ad hoc meetings as necessary.

Develops recommendations for the OMB Director on acquisition policies and requirements.

Assists the OFPP Administrator in identifying, developing and coordinating multi-agency improvement initiatives.

Furtheres integrity, fairness, competition, openness, and efficiency.

Appoints liaisons with Chief Information Officers Council, Chief Financial Officers Council, Human Resources Management Council, Small Business Procurement Advisory Council, and other councils or organizations, as appropriate.

Updates

Promotes effective business practices to ensure timely delivery of best value products & services and achieve public policy objectives.

Along with OPM, assesses and addresses hiring, training, and professional development needs of acquisition workforce.

Promotes President's Management Agenda in all aspects of acquisition system, as well as President's specific acquisition-related initiatives and policies.

Chief Acquisition Officer

Primary Policies and Directives

41 U.S.C.; codified in Federal Acquisition Regulation.

OMB Circular A-123, management's responsibility for Enterprise Risk Management and Internal Control.

Risks

Workforce attrition; aging workforce plus competition from commercial sector; mitigated by workforce investments.

Inefficient buying, effectively reduces federal capabilities; mitigated by application of "smart buying" best practices (a key Council focus).

Chief Acquisition Officer

Status of Recurring Reports to Key Stakeholders

Congressionally Mandated Reports

The two late CMRs represent Q3 and Q4 reports to Congress on Super Construction Projects. Q3 report awaits OM concurrence and Q4 awaits VHA and OM concurrences.

Q1 and Q2 were signed by SECVA on October 26, 2018.

GAO Priority Recommendations

GAO Report 17-70: VA CONSTRUCTION: Improved processes needed to monitor contract modifications, develop schedules, and estimate costs)

Per GAO: Recommendation #1 is closed as of October 10, 2018.

GAO Report 16-810: VA CONTRACTING: Improvements in policies and processes could yield cost savings and efficiency)

Currently being reviewed by GAO; awaiting GAO decision on OALC's closure request on recommendation #3.

Customer Experience Officer

CX Governance Board

Overview

Purpose: Hardwire insights and feedback from Veterans, their families, caregivers, and survivors into VA strategy and decision-making to inform and drive service recovery and performance improvement.

Participants:

Concurring Members – Under Secretaries, Chairman of Board, CVEO, CIO, and AS OPIA.

Consulted Members – All Assistant Secretaries

Board meet quarterly; Councils reporting to Board meet monthly.

Decision making process: Consensus – elevated to DEPSEC.

Elevation criteria: *Still under development.*

How decisions are communicated: *Still under development.*

Process to monitor implementation: Review of progress made by Councils reporting to Board.

Updates

Implementation of Secretary's Customer Service Policy.

Standing up Veterans Insight Council and expanding data reported to ensure enterprise decisions are powered by Veteran Signals.

Supports cross-cutting, Enterprise issues in alignment with PMA and A-11 such as Digital Modernization, Enterprise Contact Center standards and operations, Enterprise Outreach Strategy, and Service Recovery.

Pursuing Enterprise models of operations that are based in the VEO CX Framework and consistent with industry best practices.

Customer Experience Officer

CX Governance Board

Primary Policies and Directives

VA Customer Service Experience (CX) Policy was published August 22, 2018. Currently exploring the need for policies and directives in:

Digital domain requirements

Outreach

Service Recovery

Authoritative Data Sources with the Data Governance Council

Exploring opportunities to influence existing policies and directives with CX best practices.

Risks

CX Governance Board is planning the first meeting in early 2019:

Participation and support from concurrence members required to tackle difficult Enterprise decisions.

Timely establishment of the Veteran Insight Council:

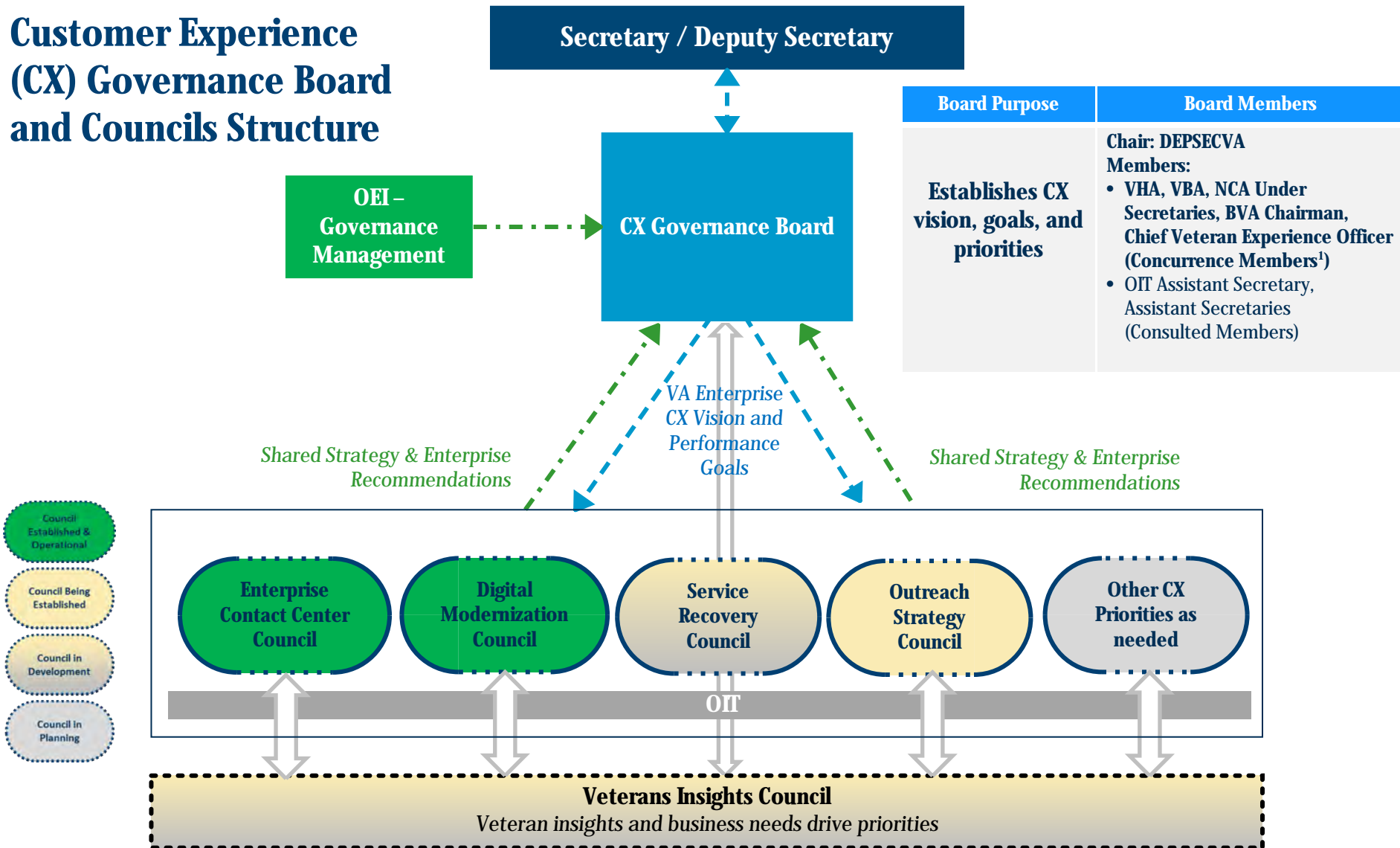
Support is needed in consolidating data stream inputs across the Enterprise to facilitate better decision-making.

IT UFR in FY19 Contact Center Modernization:

OIT will address the FY19 UFR.

Customer Experience Officer

Customer Experience (CX) Governance Board and Councils Structure



Chief Human Capital Officer

CHCOC

(Chief Human Capital
Officers Council)

Upcoming Events

Deputy CHCO Meeting (November 13, 2018)

Full Council Meeting (December 4, 2018)

Employee Engagement

President's Management Agenda

Priority Goal 3: Improve Performance Management and Engagement

20-20-20 Mandate (bottom 20% of the lowest scoring, level work units
by component/bureau)

Report Due November 15, 2018

Training Leaders

Upcoming Meeting

Next Meeting scheduled for December 5, 2018

No significant issues to report

DIVAC

(Diversity and Inclusion in
VA Council)

Membership Updates

Currently updating membership (VIEWS 117563)

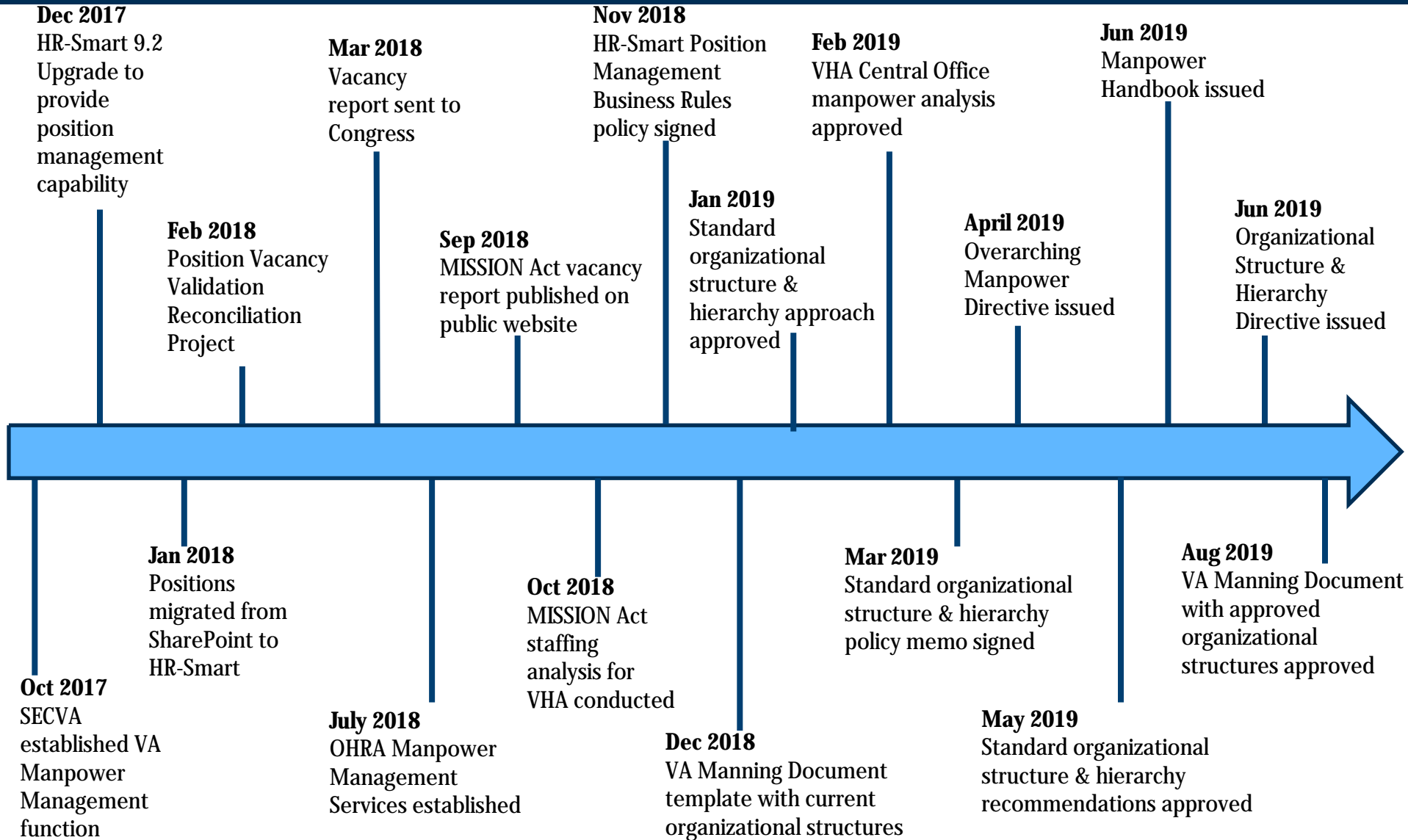
Next DIVAC Meeting scheduled for January 16, 2019

Management Deep Dives

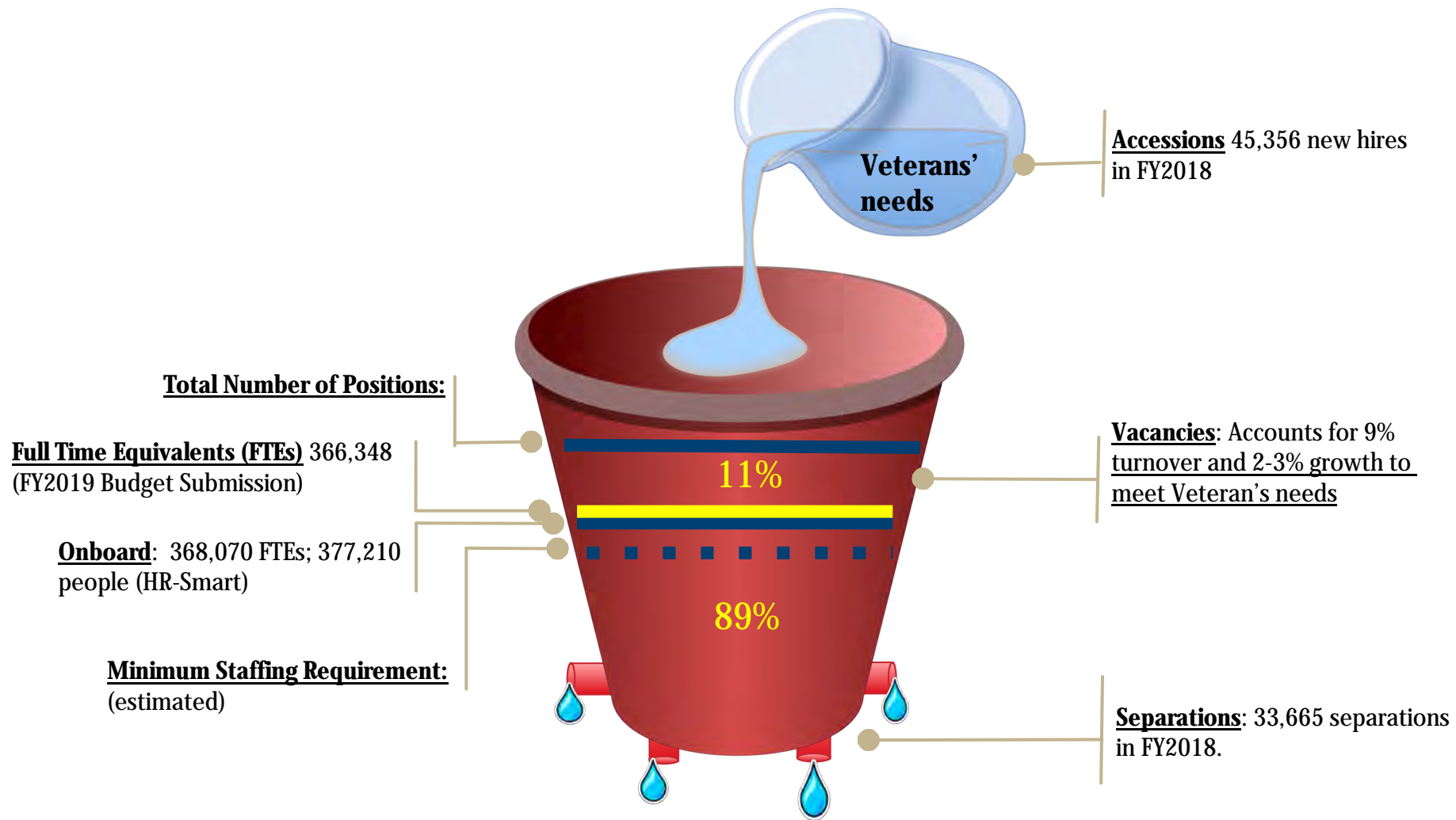
Human Resources and

Manpower Standards and Approach & Approach to Calculating Current Vacancies

Timeline to Manning Document



Flow of FTEs and Positions



Office of Accountability and Whistleblower Protection (OAWP) Policies and Operations

OAWP Metrics: Bottom Line Up Front (BLUF)

OAWP defines and manages work from a transactional process perspective.

- What:
 - Track work from receipt through resolution
 - Capture key hand-off's and milestones
- Why:
 - Provides staff and leadership a platform to discuss progress and growth in cases, FTE capacity, emerging trends or themes in submissions or case work
 - Enables constructive dialog around risks and issues as they arise – mitigate surprises

Key Performance Measures Include:

- Count Data: Incoming work, work processed; by type, by time period, by source, etc.
- Duration Data: Measure time in days between key events

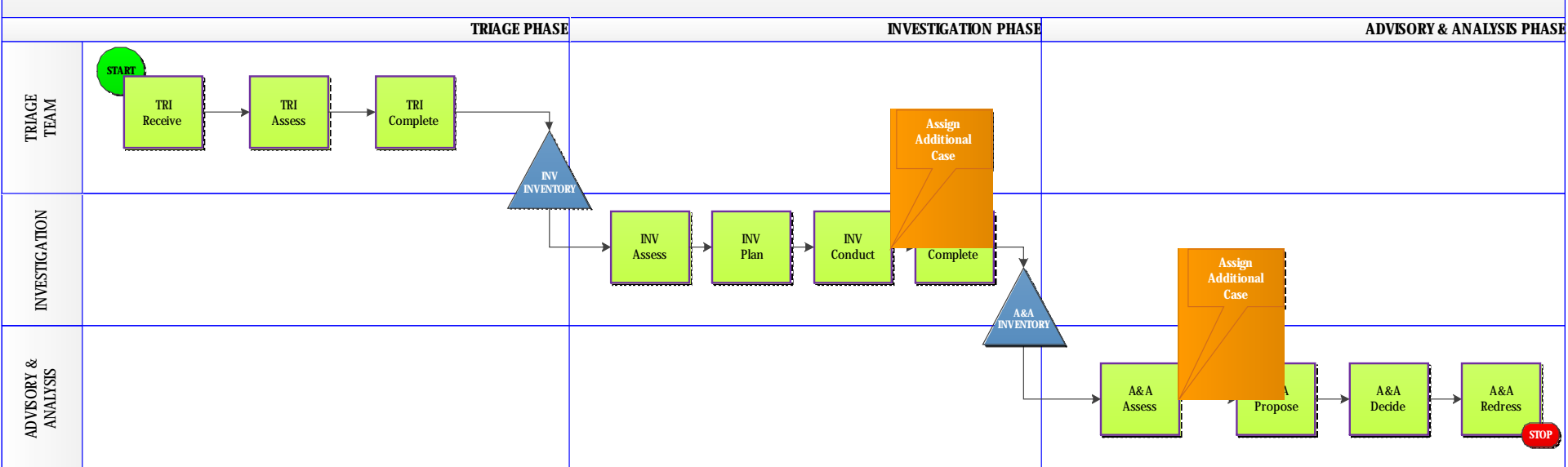
What's Next?

- Prepare Duration analysis
 - Process, policy and technology changes over time affect statistical relevance over time
 - Analyze data to identify statistically significant sub-populations of data in order to produce actionable duration analysis
- Use statistical control charts to assess process performance over time – in control or not? Differentiate between process noise and actual trends
- Assess repeatable performance and predict where process issues may arise

Process: OAWP-led Investigations

OAWP Summary Process & Metrics Map: OAWP INTERNAL INVESTIGATIONS

DATE OF MOST RECENT UPDATE 09 OCT 18



Map: Illustrates the high-level process for handling investigations and other matters within OAWP

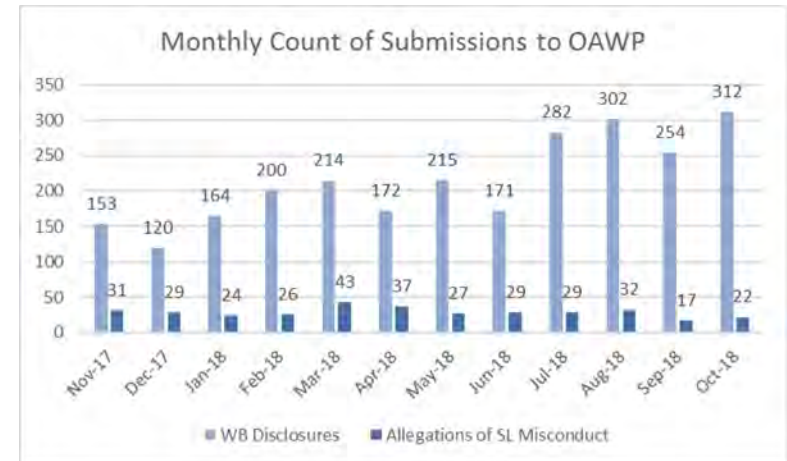
Metrics:

- Count: submissions passing through the process can be counted and monitored to ensure progress
- Duration: “ ” indicates where time stamps are taken to enable duration analysis

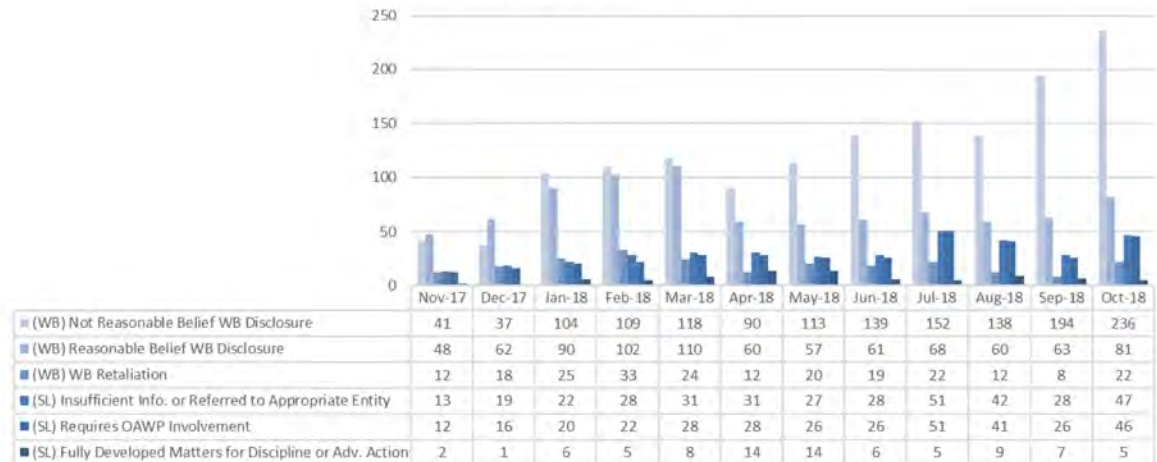
Count & Disposition of Submissions

WHAT: Count and Disposition of Submissions to OAWP

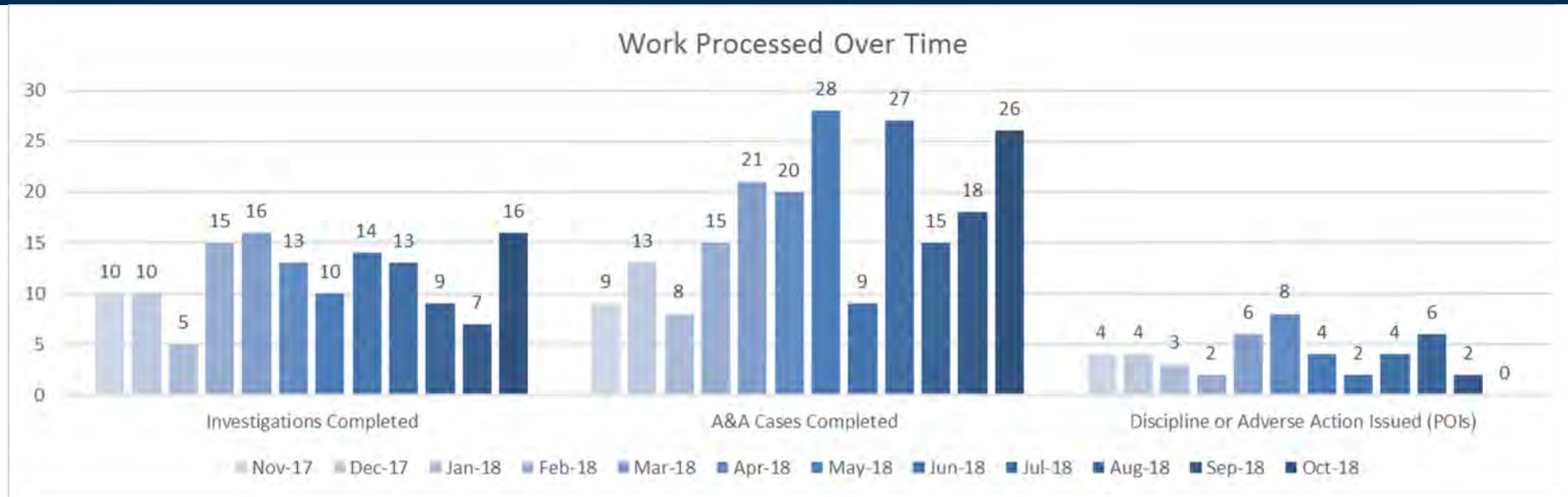
SO WHAT: Volume continues to grow across submission types



Disposition of Triaged Submissions



Count of Work Processed



- Concept for Illustration

Count of Inventory



NOTE: Concept for Illustration – data being refined for noise created by process changes during the period.

OAWP Emerging Policy & Process

OAWP Policy

Currently implementing directly from PL 115-41 and SecVA delegation February 2018

Revised SecVA delegation pending

- Adds “All GS-15 employees” to scope per SecVA testimony

- Delegates to AS, AWP authority to make determination of WB retaliation under 38 U.S.C. Section 731

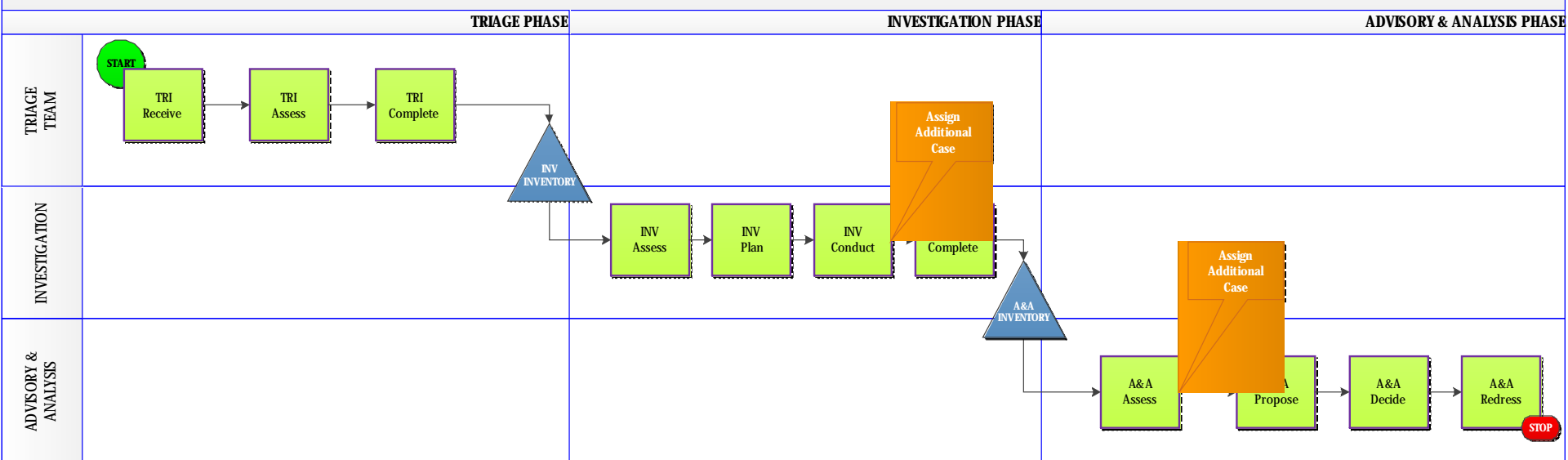
- Clarifies delegation of all items from 38 U.S.C. Section 323 to Executive Director, OAWP until AS appointed

OAWP Directive drafted, pending internal OAWP review/concurrence

Process: OAWP-led Investigations

OAWP Summary Process & Metrics Map: **OAWP INTERNAL INVESTIGATIONS**

DATE OF MOST RECENT UPDATE 09 OCT 18



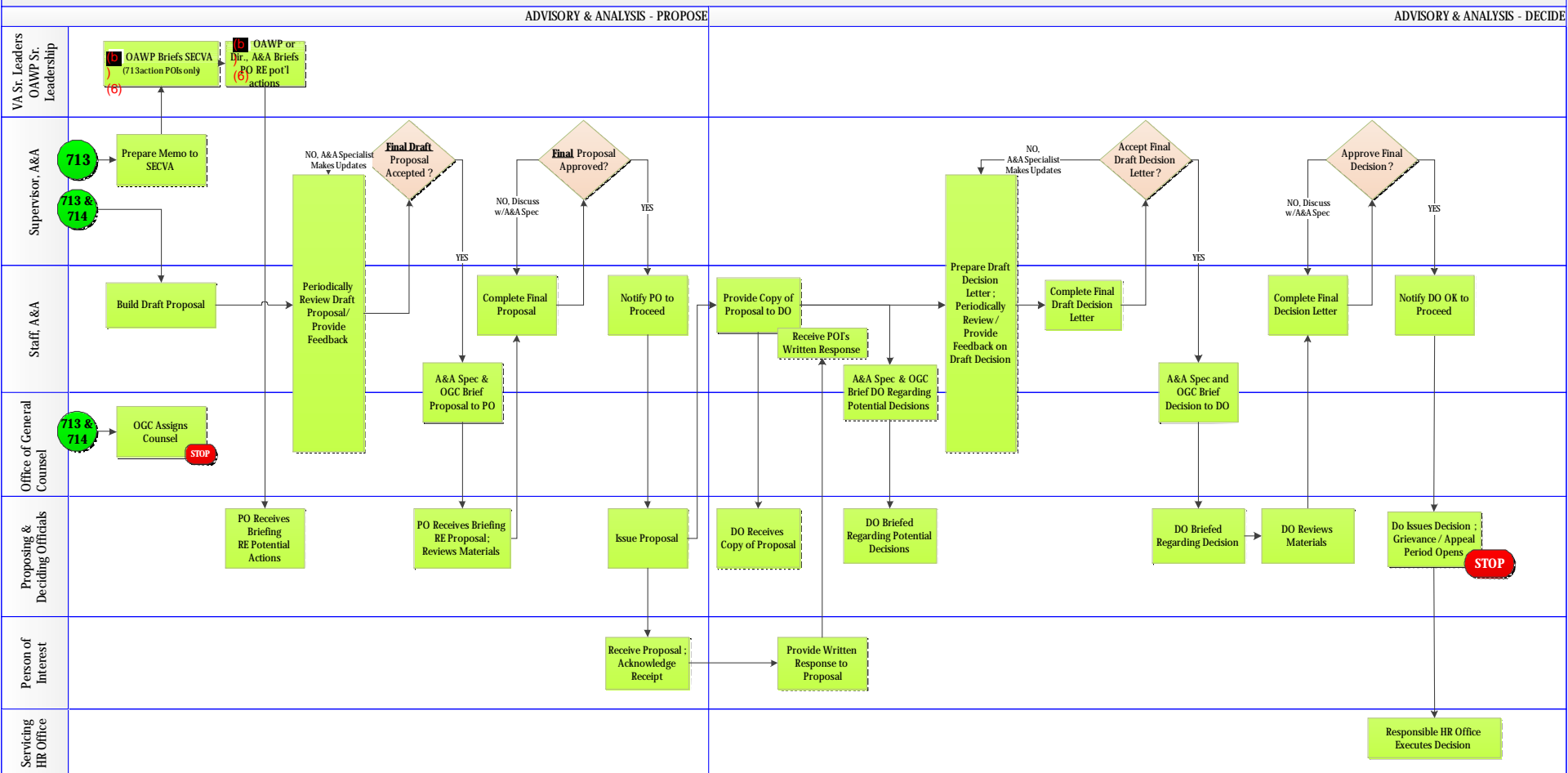
Map: Illustrates the high-level process for handling investigations and other matters within OAWP

Metrics:

- Count: submissions passing through the process can be counted and monitored to ensure progress
- Duration: “ indicates where time stamps are taken to enable duration analysis

Process: Propose-Decide

OAWP Process Map: **ADVISORY & ANALYSIS - PROPOSE**
DATE OF MOST RECENT UPDATE 09 OCT 18



- Several hand-off's and review points slow progress
- Joint steps can be difficult to coordinate (e.g., briefings to PO, DO)

Work In Process (WIP)

OAWP High-level Process Summary with FY18 Summary Data Data As Of: 06 NOV 18

FY18 Data:

97: Average Days (Straight to A&A)
165: Average Days (OAWP In-Person Investigation)
176: Average Days (OAWP Virtual Investigation)
96: Average Days (External Investigation)

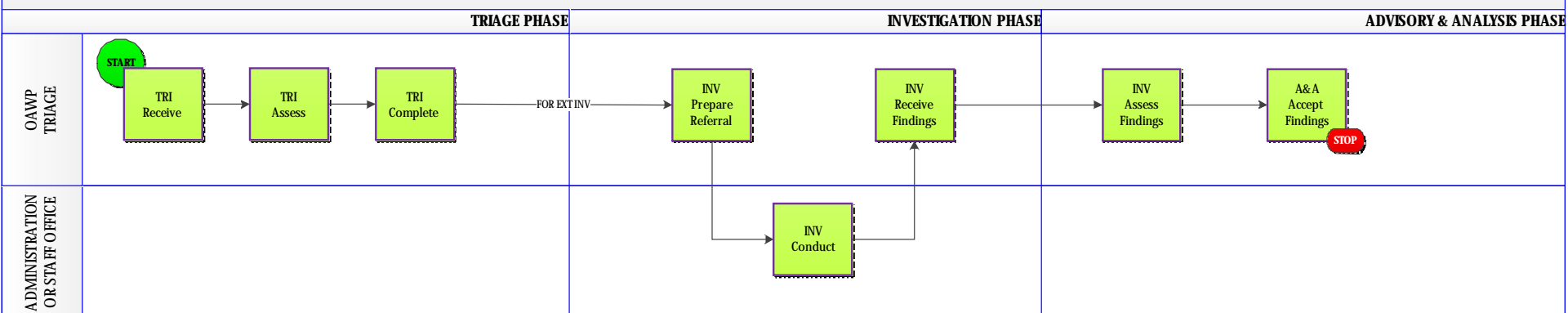
	TRIAGE	INVESTIGATION	ADVISORY & ANALYSIS
Work In Process (WIP)	351: Submissions in Triage (Open & On-Hold Items)	81: Matters in OAWP Investigation Inventory 83: Matters Being Investigated by OAWP 213: Matters Currently Referred to Another Entity for Investigation	1: Matters in OAWP Advisory & Analysis Inventory 53: Matters Being Assessed 38: POIs Being Assessed Disciplinary or Adverse Action
Work Completed Period FY18 Q4	854: Submissions Received 692: Submissions Triaged	99: Matters for OAWP Investigation 29: Investigations Completed by OAWP * 90: Matters Referred to Another Entity for WB Investigation 100: WB Investigations Completed by Another Entity * *Some investigations completed in the period started prior to the period.	49: Matters for OAWP A&A Assessment (includes "Straight to A & A" matters) 60: Matters Assessed for Potential Disciplinary or Adverse Action 14: Matters Resulted in an Action Recommendation for one or more POIs 20: POIs with Discipline or Adverse Action Recommended XX: POIs with Discipline of Adverse Action Issued 116: Referred Matters with Findings Accepted by OAWP
Durations Period FY18	NA: Average Days in Inventory 48: Average Days to Complete (SL Misconduct) 21: Average Days to Complete (WB Disclosures)	19: Average Days in Inventory (OAWP Investigations) 79: Average Days to Complete (OAWP Investigations) 87: Average Days to Complete (Investigations referred outside of OAWP) *Some investigations completed in the period started prior to the period.	16: Average Days in Inventory (Straight to A&A) 13: Average Days in Inventory (OAWP Investigation) 34: Average Days to Complete "Assess" (Straight to A&A + OAWP Investigation) 70: Average Days "Assess Complete" to "Discipline Issued" (Straight to A&A + OAWP Investigation)
OAWP Capacity	FTE: 19 Triage Specialists (authorized 20) Capacity (point in time): * TBD/ specialist (Standard) (being assessed now) * TBD/ specialist (Standard) (being assessed now)	FTE: 27 Investigators/ HR Specialists Capacity (point in time; across Assess-Plan-Conduct): * 2-3 cases/ investigator (Standard) * 4-5 cases/ investigator (Surge) (for limited time or complexity) * 54-81 cases/ OAWP (Standard)	FTE: 10 HR Specialists Capacity (point in time): * 2 cases/ specialist (Standard) (each case may have one or more POIs) * 4 cases/ specialist (Surge) (each case may have one or more POIs) * 20 cases/ OAWP (Standard)

- Investigations Inventory is growing quickly due to policy change to direct all retaliation investigations to OAWP investigators

Process: Admin/Staff Office-led Investigations

OAWP Summary Process & Metrics Map: EXTERNAL INVESTIGATIONS(WB Disclosures for Administration or Staff Office Investigation)

DATE OF MOST RECENT UPDATE 09 OCT 18



All disclosures submitted to OAWP are assessed

Reasonable belief matters are referred for investigation (either to OAWP investigators or respective Admin/ Staff Office); OAWP receives findings and assesses outcomes

Some submissions are not WB related, and are referred to the appropriate Admin/Staff Office for review and response directly to the disclosing party (e.g., safety concerns, Veteran or family member inquiries, etc.)

IT UFR Process and Current Integrated Priority List

Unfunded Requirement (UFR) Process

UFR Process

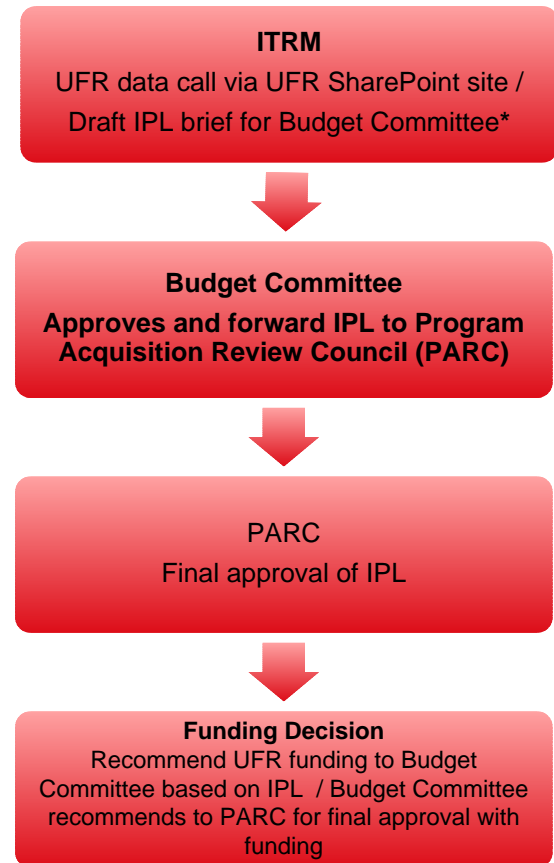
Series of actions which identifies unfunded projects, to be executable in the current fiscal year, that could be supported if funding becomes available.

Objective of the UFR Process: To create an Integrated Priority List (IPL) of UFRs.

Implementation of UFR Process: OIT Chief Financial Officer (CFO) determines there are sufficient funds to support additional projects that were not originally included in the Budget Operating Plan.

Outcome of the UFR Process: An unfunded IPL that is vetted and approved via the UFR Prioritization Working Group and OIT governance structure resulting in a funding decision (see IPL Process).

Unfunded Integrated Priority List (IPL) Process



**For FY19: Initial data call to submit UFRs will occur in Q1 (or as soon as policy is approved) for the upcoming Fiscal Year*

VA Operational Planning Office of Enterprise Integration

VA Operational Planning & Governance

Problem Statement: VA is currently unable to understand, measure, or manage successful achievement of the SECVA Priorities or effectively respond to emerging external requirements.

Objective: Leverage the Emerging Governance Structure and Processes to:

- Establish Planning Standards for VA Programs and Initiatives

- Document Intended Outcomes

- Create Measurable Objectives

- Enable Performance Improvement

- Drive Accountability

OEI's role:

- Establish Program Planning Standards

- Coordinate support for Programs and Initiatives

- Support identification and resolution of critical needs and/or operational issues

- Address systemic management and execution issues

- Support leaders in effectively managing their Programs and Initiatives

Intended Outcome:

- Create greater transparency for VA senior leadership regarding progress against achieving SECVA Priorities.

- Enhanced execution of Programs and Initiatives by surfacing and resolving issues impeding progress.

FY19 Operational Plans Candidates (1 of 2)

VHA

Mission Act

Community Care consolidation
 Telehealth expansion
 Caregiver compensation expansion
 Assessment of Infrastructure and Resources

Mental Health

Filling MCOs for Mental Health
 Implementing National Suicide Prevention EO

VHA Modernization

Supply Chain (Business Transformation)

Modernizing VHA supply chain*

VHA (cont)

Geographically Underserved Populations
 Infrastructure gaps
 Providing Healthcare
 Mental Healthcare

VBA

Forever GI Bill*

Office of Transition and Economic Development milestones

BVA

Appeals Modernization*

NCA

Assumption of Veteran Cemeteries from DoD

* OEI will consolidate existing plans into Plan Format

FY19 Operational Plans Candidates (2 of 2)

OEI & OIT

Business requirements integration

Data integration

OIT

Interoperability of VA between Commercial
Care Provider IT Systems

OHRM

Manpower plan

Filling Mission Critical Occupations (MCOs)

EHRM

Execution plan

OAWP

Holding Executive leadership accountable

Establishment of roles and functions between
OWAP, Internal Controls, OGC, OIG

OM

Stop Fraud, Waste, and Abuse*

OALC

TBD (Business Transformation)

VEO

Veteran Experience Strategy implementation

Woman Veteran Equities

Providing Healthcare

Ending Homelessness

Improving Employment

Providing Mental Healthcare

* OEI will consolidate existing plans into common plan format

Operational Plan - Essential Elements of Information

Organizational or Program Mission

Vision Statement

Program Owner & Program Organizational Structure

Program/Initiative Objectives and measurable outcome targets

- Schedule (activities sequenced) and Milestones

- Customer Service Improvement Elements/Targets

- Performance Measures (baseline, goals, and stretch goals)

Resources

- Staffing Plan (Gov't FTE)

- Contract Support Requirements

- IT Requirements

- Acquisition Strategy

- Resource Gaps (if applicable) and impact on Performance Measures

- Dependencies

Risks/Issues & Mitigation Strategies

VA Operational Planning Model

Action	SECVA/ DEPSEC/ COSVA	Plan Owners	Staff Offices (Enabling Support)	Governance Board	Office of Enterprise Integration
Planning Standards				VAOB	✓
Program/Initiative Selection & Annual Objectives Refresh	✓			VAEB	
Operational Plan Development		✓	✓	VAOB	
Quality Assurance				VAOB	✓
Operational Plan Execution		✓	✓	VAOB	
Performance Management & Oversight				VAEB (Quarterly) VAOB (Monthly)	✓
Issue Resolution	✓			VAEB	

Back Up Slides

Enterprise Governance Bodies

Chair

SECVA

SECVA Stand-up (Meets Daily)

- Brief SECVA on key daily issues

Management Synchronization Meeting (Meets Weekly)

- Major near-term (30-day) milestones
Key issues and immediate Secretary decisions

VA Executive Board (VAEB) (Meets quarterly or as needed)

- VA strategy, policy, major investments

Under Secretaries Meeting (Meets Weekly)

- Execution priorities and strategic planning

VA Operations Board (Meets Bi-Monthly)

- Reviews budget execution, operations and performance; OIG/GAO high risk and issue management

Modernization Board (Meets Monthly (or as needed))

- Reviews performance and execution of VA Modernization initiatives/priorities & reform efforts

Mission Act Enterprise Program Execution Reviews (Meets Weekly/As Needed)

- Detailed updates (cost, schedule and performance) of targeted initiatives

EHRM Enterprise Program Execution Reviews (Meets Weekly/As Needed)

- Detailed updates (cost, schedule and performance) of targeted initiatives

President's Management Council* (Meets Quarterly)

- Oversees implementation of government-wide management policies/programs

Joint Executive Committee* (Meets Quarterly)

- Recommends strategic direction for the joint VA/DOD coordination/sharing
- Co-chaired by SECVA semi-annually
- Bi-monthly touchpoints with DOD

COSVA

Chief of Staff Council Meeting (Meets Weekly)

Manages execution of decisions made from other boards

AS/US/ Exec. Dir

Administration Governance
Bodies

CXO Governance Bodies

Strategic

Execution

Synchronization

*External Cross-Government bodies managed by the DEPSECVA

OGC POCs

Financial Management Business Transformation

Procurement Law Group SMEs: Bob Fleck and (b) (6) (PrLG);

The FMBT program (the purpose of which is to modernize the VA's legacy Financial Management System) was originally a procurement being administered by the United States Department of Agriculture (USDA) as a shared service, but USDA in December 2017 notified VA that it would no longer be the Federal Shared Service provider and VA was required to take over administration of all USDA awarded task orders. Accordingly, OGC has to provide guidance on transferring software licenses, terminating certain software licenses, acquiring new software licensing, modifying contracts, and awarding four new contracts (the awarded contracts ranged from \$12 million to \$750 million) in a compressed period of time in order to ensure the FMBT program continued without interruption.

Secondarily, involved through contracts supporting supply chain management objectives including the JEC, Joint Executive Counsel a DoD/ VA committee to support collaboration in efforts to provide medical care and share resources, routinely releases objectives requiring support from both PrLG. Most recent FY17/18 was the use of "ECat" a DoD interface which allows for an assisted acquisition to DoD.

Revenue Law Group SMEs: (b) (6) and (b) (6)

Supply Chain Transformation

Procurement Law Group SMEs: Bob Fleck and (b) (6) (PrLG)

Involved via procurement of follow on contract for commodities Medical Surgical Prime Vendor. PrLG has supported this effort over the last decade, and since FY16 also supported the NexGen approach and the 2.0. Currently working with OAL and VHA leadership and acquisitions to identify sources and coordination of efforts. Multiple inquiries by HVAC and SVAC as well as industry. Some litigation regarding the execution was resolved in September (Electra-Med matter).

Telehealth

Health Care Law Group SME: (b) (6) (this issue also involves the Personnel Law Group)

- Provided technical assistance for MISSION Act legislation
- Reviewed regulation that preceded MISSION Act legislation
- Addressing questions concerning prescribing of controlled substances
- Providing guidance on legal questions presented by program

Procurement Law Group SMEs: Bob Fleck and (b) (6) (PrLG);

Review of the contracts underlying the COTs and cloud services to ensure that execution of the project. Our office worked in FY16/17 to ensure that all items on contract were in scope. As an IDIQ additional work will be needed over the contract life cycle.

Information Law Group SME: (b) (6)
data governance and security issues.

Personnel Law Group SME: (b) (6) with (b) (6) and (b) (6)

assisted in developing regulations and working w VHA on anywhere-to-anywhere initiative (allowing VA providers who are not providing telehealth to allow them to provide services anywhere as long as its within their scope of practice).

OGC POCs

STOP Fraud, Waste and Abuse

Health Care Law Group SME: (b) (6) (Medicare data)

Participating in discussions about how this information may be used in future community care program.

(b) (6) -Participated in a discussion with ILG concerning current ability to use information from CMS.

Procurement Law Group SME: Bob Fleck and (b) (6)

Involved through Federal Acquisition Regulation (FAR) requirements (3 and 9.4) for procurement integrity as well as avoidance of conflict of interest.

This includes work of attorneys in specific contract matters as well as our Debarment and Suspension support.

Personnel Law Group SME: (b) (6)

advised on whether they can hire investigators (yes) and advising on follow-up issues on info sharing related to investigator findings.

Navigator Customer Experience

Not available

HR Modernization

Personnel Law Group SME: (b) (6)

met with them back in January but haven't heard anything from them since.

Appeals Modernization

Benefits Law Group SME: (b) (6)

Has worked closely with BVA and multiple VBA program offices to implement the Appeals Modernization Act.

Assisted in coordinating and reconciling inputs from multiple offices into a comprehensive proposed rule adding or revising more than 150 CFR sections.

Assisted VBA and BVA in implementing pilot programs to test aspects of the modernized appeals system.

Assisting in analyzing comments on proposed rule, developing responses for final rule notice.

Health Care Law Group – Lead SME: (b) (6) (HCLG has other SME's working with particular VHA Programs)

Working with VHA to help them understand requirements of the Appeals Modernization Act and how that will impact individual programs.

Working with VHA programs on developing templates for notices of decisions.

Working with VHA to develop interim final rule.

OGC POCs

Forever GI Bill

Benefits Law Group SME: (b) (6)

Provided Education Service advice regarding statutory interpretation.

Has been reviewing Education Service's preliminary drafts of the proposed rulemaking.

Procurement Law Group SMEs: Bob Fleck and (b) (6)

PrLG has supported VBA in revising the contracts supporting these programs. We have also advised regarding endorsements.

Mental Health Joint Action Plan

Health Care Law Group SMEs: (b) (6)

Providing legal guidance on VA's authorities to provide treatment

Providing legal review of materials developed for the initiative

Electronic Health Record Modernization (EHRM)

Procurement Law Group SMEs: Bob Fleck and (b) (6)

OGC was heavily involved in crafting the public interest determination and findings (D&F) the allowed a sole-source firm-fixed-price approximately \$10 Billion, Indefinite Delivery/Indefinite Quantity (ID/IQ) contract to Cerner to acquire the EHR system being deployed by the Department of Defense (DoD) and related services for deployment and transition across the VA enterprise in a manner that meets VA needs enabling seamless healthcare to Veterans and qualified beneficiaries. OGC was instrumental in supporting this award throughout all aspects of the program, from the pre-award contract negotiation, contract and multiple task order awards, and successful defense of bid protest challenges at the Agency and Federal Court level.

Personnel Law Group SMEs: (b) (6) and (b) (6)

hiring staff as T38 providers and helped draft legislation to accomplish this and advised on interim process with dotted line authority to allow T38 pay retention.

MISSION Act

Health Care Law Group SME's:

Community Care – (b) (6)

Caregivers – (b) (6)

Providing legal guidance on MISSION Act provisions to facilitate decision-making

Assisting in the drafting and development of necessary regulations implementing the law

Legal review of regulations

Personnel Law Group SME: (b) (6) and (b) (6)

podiatrist pay to ensure its similar to physician pay (b) (6) also advising on education programs (b) (6)

Monthly Execution Review (MER) – Congressional Reports

Data as of September 2018

Office of Budget				
Congressional Reports Pending as of October 24, 2018				
64 Overdue and 32 Coming Due on October 30, 2018 or later				
	LEGEND:	Reports Overdue	Reports Coming Due	Reports Completed
Report Topic	Responsible Organization	Date Due to Budget Office	Date Due to Congress	Date to Hill
Encouraging Public-Private Partnerships - 1st Q tr.	CFM	1/16/2018	1/30/2018	
National Outreach and Awareness Marketing Campaign - 1st Q tr.	OPIA	1/16/2018	1/30/2018	
Small, minority-and women-owned businesses - 1st Q tr.	OSVA	1/16/2018	1/30/2018	
Quarterly reporting - Major Construction - 1st Q tr.	OALC/CFM	1/16/2018	1/30/2018	
Appointment scheduling system	OIT	4/9/2018	4/23/2018	
Veterans data protection	OIT	4/9/2018	4/23/2018	
Spending plan	VHA	4/9/2018	4/23/2018	
Encouraging Public-Private Partnerships - 2nd Q tr.	CFM	4/16/2018	4/30/2018	
National Outreach and Awareness Marketing Campaign - 2nd Q tr.	OPIA	4/16/2018	4/30/2018	
Small, minority-and women-owned businesses - 2nd Q tr.	OSVA	4/16/2018	4/30/2018	
Quarterly reporting - Major Construction - 2nd Q tr.	OALC/CFM	4/16/2018	4/30/2018	
Central office responsiveness	OCLA	4/16/2018	4/30/2018	
West Los Angeles, California seismic corrections	CFM/OAEM	5/9/2018	5/23/2018	
Bakersfield outpatient clinic	CFM	5/9/2018	5/23/2018	
White House Veterans Complaint Hotline	VEO	5/9/2018	5/23/2018	
Hiring delays	VHA	5/9/2018	5/23/2018	
Kingdomware Decision	OIT	5/9/2018	5/23/2018	
Cybersecurity	OIT	5/9/2018	5/23/2018	
Rare cancers	VHA	6/8/2018	6/22/2018	
Improving Federal Burn Pits Registry	VHA	6/8/2018	6/22/2018	
Women's access to medical services	CFM	6/8/2018	6/22/2018	
Delayed provider payments	VHA	6/8/2018	6/22/2018	
Bakersfield outpatient clinic	CFM	7/9/2018	7/23/2018	
Financial Management and Health Care Delivery	VHA	7/9/2018	7/23/2018	
Mental health services training for community providers	VHA	7/9/2018	7/23/2018	
Position vacancies	VHA	7/9/2018	7/23/2018	
Rural caregivers	VHA	7/9/2018	7/23/2018	
Encouraging Public-Private Partnerships - 3rd Q tr.	CFM	7/16/2018	7/30/2018	
Long-Term Care - 3rd Q tr.	VHA	7/16/2018	7/30/2018	
Central office responsiveness - 3rd Q tr.	OCLA	7/16/2018	7/30/2018	
National Outreach and Awareness Marketing Campaign - 3rd Q tr.	OPIA	7/16/2018	7/30/2018	
Small, minority-and women-owned businesses - 3rd Q tr.	OSVA	7/16/2018	7/30/2018	

Monthly Execution Review (MER) – Congressional Reports

Data as of September 2018

Congressional Reports Pending as of October 24, 2018				
64 Overdue and 32 Coming Due on October 30, 2018 or later				
	LEGEND:	Reports Overdue	Reports Coming Due	Reports Completed
Report Topic	Responsible Organization	Date Due to Budget Office	Date Due to Congress	Date to Hill
Quarterly reporting - Major Construction -3rd Q tr.	OALC/CFM	7/16/2018	7/30/2018	
High-cost areas	VHA	9/7/2018	9/21/2018	
Women's health	VHA	9/7/2018	9/21/2018	
Corporate Planning and High Performing Networks	VHA	9/7/2018	9/21/2018	
Corporate Planning and High Performing Networks	VHA	9/7/2018	9/21/2018	
National Center for Post-Traumatic Stress Disorder	VHA	9/7/2018	9/21/2018	
Treatment for Post-Traumatic Stress Disorder	VHA	9/7/2018	9/21/2018	
Opioid Safety	VHA	9/7/2018	9/21/2018	
Opioid Addiction Treatment Protocols	VHA	9/7/2018	9/21/2018	
Dependents and Prescription Drug Monitoring Programs	VHA	9/7/2018	9/21/2018	
Orthotics and Prosthetics Workforce	VHA	9/7/2018	9/21/2018	
DoD and VA Prescription Drug Purchasing	VHA	9/7/2018	9/21/2018	
Center for Compassionate Innovation	VHA	9/7/2018	9/21/2018	
Hospice Care	VHA	9/7/2018	9/21/2018	
Home and Community Based Services	VHA	9/7/2018	9/21/2018	
Burn Pits Research	VHA	9/7/2018	9/21/2018	
Filling Vacant Positions	HRA	9/7/2018	9/21/2018	
Construction Contracting Outreach	CFM	9/7/2018	9/21/2018	
Medical staff retention	VHA	9/7/2018	9/21/2018	
Management reforms	OPP	9/7/2018	9/21/2018	
Legacy system decommissioning plan	OIT	9/7/2018	9/21/2018	
Veterans Service Centers	VBA/VHA	9/14/2018	9/28/2018	
Financial Hardship and Bankruptcy	OGC	9/14/2018	9/28/2018	
Rural Veterans Coordination Pilot	VHA	9/14/2018	9/28/2018	
Assessing Homelessness in Rural Areas	VHA	9/14/2018	9/28/2018	
Prescription Drug Monitoring Program Utility	VHA	9/14/2018	9/28/2018	
National Center for Posttraumatic Stress Disorder (PTSD)	VHA	9/14/2018	9/28/2018	
Postpartum depression	VHA	9/14/2018	9/28/2018	
HUD-VA SH program	VHA	9/14/2018	9/28/2018	
Maternity care benefit, survey, and education campaign	VHA	9/14/2018	9/28/2018	
Training for VA personnel engaged in facility management	CFM	9/14/2018	9/28/2018	
Deferred maintenance	NCA	9/14/2018	9/28/2018	

Monthly Execution Review (MER) – Congressional Reports

Data as of September 2018

Congressional Reports Pending as of October 24, 2018				
64 Overdue and 32 Coming Due on October 30, 2018 or later				
	LEGEND:	Reports Overdue	Reports Coming Due	Reports Completed
Report Topic	Responsible Organization	Date Due to Budget Office	Date Due to Congress	Date to Hill
Filling Vacant Positions	HRA	10/16/2018	10/30/2018	
Caregivers program - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Hepatitis C Treatment - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Encouraging Public-Private Partnerships - 4th Q tr.	CFM	10/16/2018	10/30/2018	
Long-Term Care - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Veterans Health Administration - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Claims Processing - 4th Q tr.	VBA	10/16/2018	10/30/2018	
Central office responsiveness - 4th Q tr.	OCLA	10/16/2018	10/30/2018	
Performance reporting - September	VBA	10/16/2018	10/30/2018	
Disability Claims Processing - September	VBA	10/16/2018	10/30/2018	
OIT Expenditure Plan - September	OIT	10/16/2018	10/30/2018	
Disability Claims - 4th Q tr.	BVA	10/16/2018	10/30/2018	
Disability Claims - 4th Q tr.	VBA	10/16/2018	10/30/2018	
National Outreach and Awareness Marketing Campaign - 4th Q tr.	OPIA	10/16/2018	10/30/2018	
Small, minority-and women-owned businesses - 4th Q tr.	OSVA	10/16/2018	10/30/2018	
Quarterly reporting - VHA - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Quarterly reporting - Choice Act - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Quarterly reporting - Hep C - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Quarterly reporting - Transfers - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Quarterly reporting - GenAd - 4th Q tr.	OM-Budget	10/16/2018	10/30/2018	
Quarterly reporting - BVA - 4th Q tr.	BVA	10/16/2018	10/30/2018	
Quarterly reporting - VBA GOE - 4th Q tr.	VBA	10/16/2018	10/30/2018	
Quarterly reporting - VBA - 4th Q tr.	VBA	10/16/2018	10/30/2018	
Quarterly reporting - NCA - 4th Q tr.	NCA	10/16/2018	10/30/2018	
Quarterly reporting - OIT - 4th Q tr.	OIT	10/16/2018	10/30/2018	
Quarterly reporting - Major Construction - 4th Q tr.	OALC/CFM	10/16/2018	10/30/2018	
Quarterly reporting - FTE - 4th Q tr.	OM-Budget	10/16/2018	10/30/2018	
Veterans Electronic Health Record - 4th Q tr.	EHR	10/16/2018	10/30/2018	
Caregivers	VHA	1/9/2019	1/23/2019	
Expenditure plan - Minor Construction	O AEM	3/8/2019	3/22/2019	
Medical staff retention	VHA	3/8/2019	3/22/2019	
Demand profile	VHA	3/9/2019	3/23/2019	

Upcoming VAOB Meetings

November 26 – Budget Execution and Performance Review

December 10 – Management Issues

December 24 – Cancelled

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Bcc:
Subject: VA Operations Board (VAOB) Meeting
Date: Tue Oct 30 2018 17:33:04 CDT
Attachments: 181113 VAOB Final.pptx

StartTime: Tue Nov 13 09:00:00 Central Standard Time 2018
EndTime: Tue Nov 13 11:00:00 Central Standard Time 2018
Location: Omar Bradley Conference Room (OBCR)
Invitees: VA OB Members
Recurring: No
ShowReminder: No
Accepted: Yes
AcceptedTime: Thu Nov 01 15:08:00 Central Daylight Time 2018

Good Evening, please accept our apologies for the delay with the attachments.

Copies will be provided at the meeting. We sincerely thank you for your patience and flexibility.

Chair: Acting Deputy Secretary, Mr. Jim Byrne

Principal Attendees: Assistant Secretaries, Under Secretaries and Key Officials

Purpose: The VAOB has bi-monthly meetings every 2nd and 4th Monday. The 2nd Monday meeting focuses on management issues (i.e., CXO updates, Congressionally Mandated/Tracked Reports, and Executive Correspondence). The 4th Monday meeting focuses on budget execution and performance.

Due to the holiday on Monday, November 12th (Veteran's Day), this meeting is rescheduled to Tuesday, November 13th.

Read ahead materials will be provided NLT two business days prior to the scheduled meeting. If your organization's POCs require updating, do not hesitate to contact EGM with these changes.

If you have any questions, please do not hesitate to contact Ms. (b) (6) at 202-266-(b) (6) or (b) (6) va.gov, or the Enterprise Governance Management (EGM) Team at EGMTeam@va.

gov. Thank you and have a great day.

Sincerely,

EGM Team

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Last Modified: Tue Oct 30 16:33:04 CDT 2018

VA Operations Board Meeting

November 13, 2018
Omar Bradley Conference Room

Agenda

Item #	Topic	Briefer
1	Opening Comments	Mr. Jim Byrne, Acting Deputy Secretary of Veterans Affairs
2	Introduction	Dr. Melissa Glynn, Assistant Secretary for Enterprise Integration
3	Recurring Updates a. Congressionally Mandated Reports b. Executive Correspondence	Mr. Brooks Tucker, Assistant Secretary for Congressional and Legislative Affairs Mr. (b) (6) Office of the Executive Secretariat
4	CXO Updates	
	a. Chief Financial Officer	Mr. Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer
	b. Chief Information Officer	Mr. Camilo Sandoval, Executive-in-Charge, Office of Information and Technology
	c. Chief Acquisition Officer	Ms. Karen Brazell, Principal Executive Director and Chief Acquisition Officer, Office of Acquisition, Logistics and Construction
	d. Customer Experience Officer	Dr. Lynda Davis, Chief Veterans Experience Officer
	e. Chief Human Capital Officer	Ms. Jacquelyn Hayes-Byrd, Acting Assistant Secretary for Human Resources and Administration

Agenda

Item #	Topic	Briefer
5	Management Deep Dive – Manpower Standards and Approach and Approach to Calculating Current Vacancies and Manpower	Ms. Carin Otero, Deputy Assistant Secretary, Office of Human Resources Management
6	Management Deep Dive – OAWP Policies and Operations	Mr. Kirk Nicholas, Executive Director, Office of Accountability and Whistleblower Protection
7	Management Deep Dive – IT UFR Process and Current Integrated Priority List	Mr. Camilo Sandoval, Executive-in-Charge, Office of Information and Technology
8	Management Deep Dive – VA Operational Planning	Mr. John Basso, Deputy Assistant Secretary, Planning and Performance Management, Office of Enterprise Integration
9	Upcoming VA Operations Board Meetings a. November 26 – Budget Execution and Performance Review b. December 10 – Management Issues	Mr. Jon Rychalski, Assistant Secretary for Management and Chief Financial Officer Dr. Melissa Glynn, Assistant Secretary for Enterprise Integration
10	Closing Remarks and Actions	Mr. Jim Byrne, Acting Deputy Secretary for Veterans Affairs

VAOB Action Item Tracker

#	Action Item	Owner(s) (Lead/Support)	Due Date (or weekly default)	Status/Notes (Include anticipated/completion dates)	Next Steps, if any, after completion of Action Item
1	Provide Mr. Dat Tran and Mr. John Basso with Management issues that your organization would like to see reviewed in the VAOB	ALL	Ongoing	Ongoing.	
2	Meet with OIT to align VA & OIT Governance Boards	OEI	11/20	Ongoing. Preliminary meetings held with OEI and OIT. Additional meetings are being scheduled.	
3	Provide a list of proposed Customer Service Performance Measures for SES Performance Plans	OEI VEO	11/20	Memo dated 10/26/18 in VIEWS for comments.	
4	Every Office must provide updates to their Operational and Strategic Performance measures to OEI's Director of Performance, (b) (6) (b) (6) va.gov)	All	11/20	Ongoing. OEI has met with all organizations. Awaiting final measures and data.	
5	Review the list of Congressional Reports and identify which report should be moved to the 'Unnecessary Report List'. Send updates to OEI's Director of Performance, (b) (6) (b) (6) va.gov)	All	11/20	Ongoing. See Back Up slides.	
6	Provide a list of OGC POCs to address various legal issues within the agency	OGC	11/19	Completed. See Back Up slides.	None

Recurring Updates

Office of Congressional and Legislative Affairs

Congressionally Mandated Reports

Congressionally Mandated Reports

PAST DUE as of November 5, 2018

14 Congressionally Mandated Reports (CMRs) for FY18 (1 with ExecSec/OSVA for SECVA signature):

VHA: 9	(oldest 249 days overdue)
OALC: 1	(98 days overdue)
HRA: 1	(85 days overdue)
OIT: 2	(oldest 81 days overdue)
VBA: 1	(61 days overdue)

7 CMRs for FY19

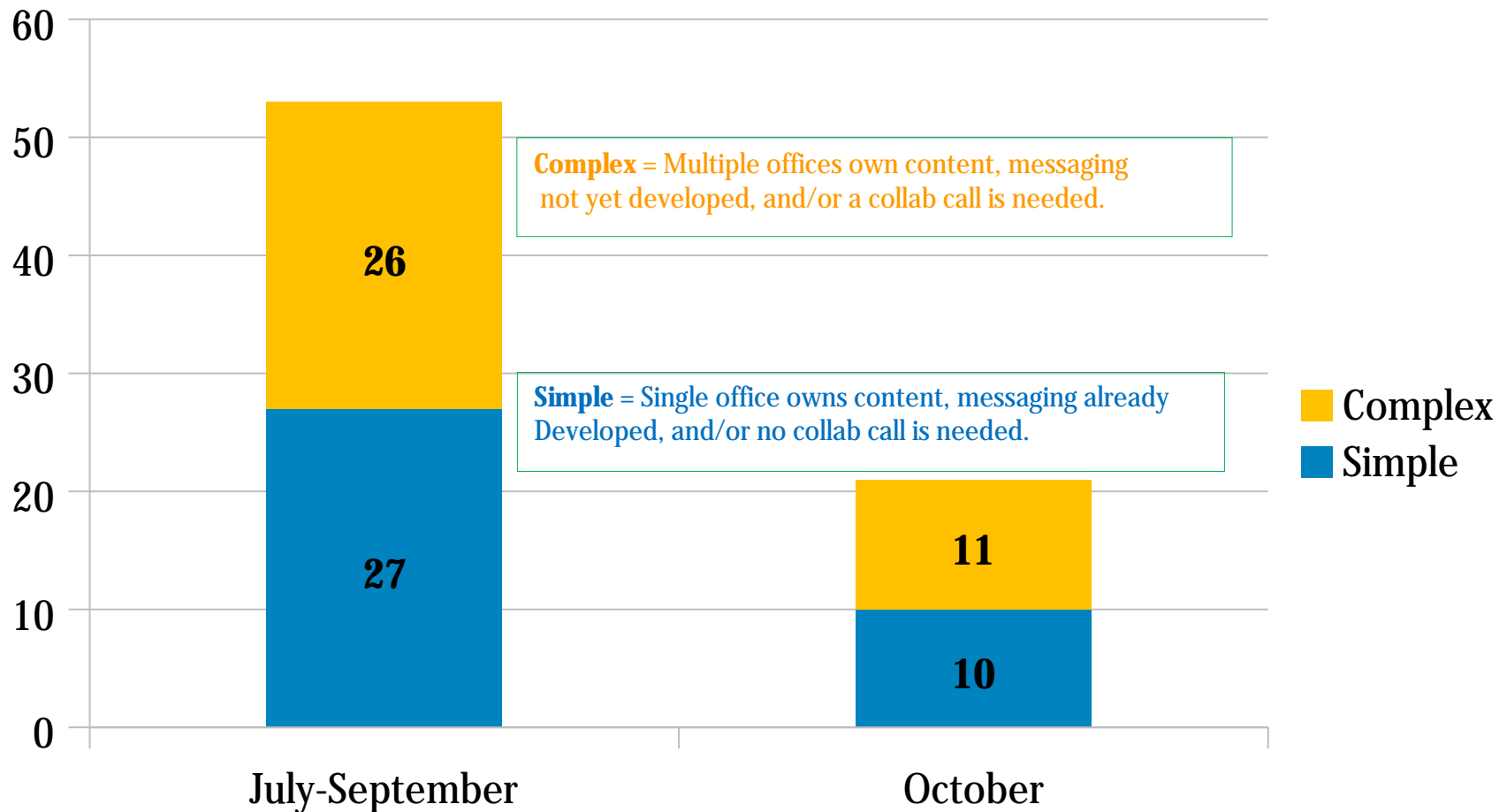
FYI

VIEWS letter for November 13, 2019 HVAC Health Hearing cleared OMB on November 2, 2018 with ExecSec for signature (two bills; hearing notice was very late; therefore, no opportunity was provided for a written testimony to be submitted).

Office of the Executive Secretary (EXECSEC)

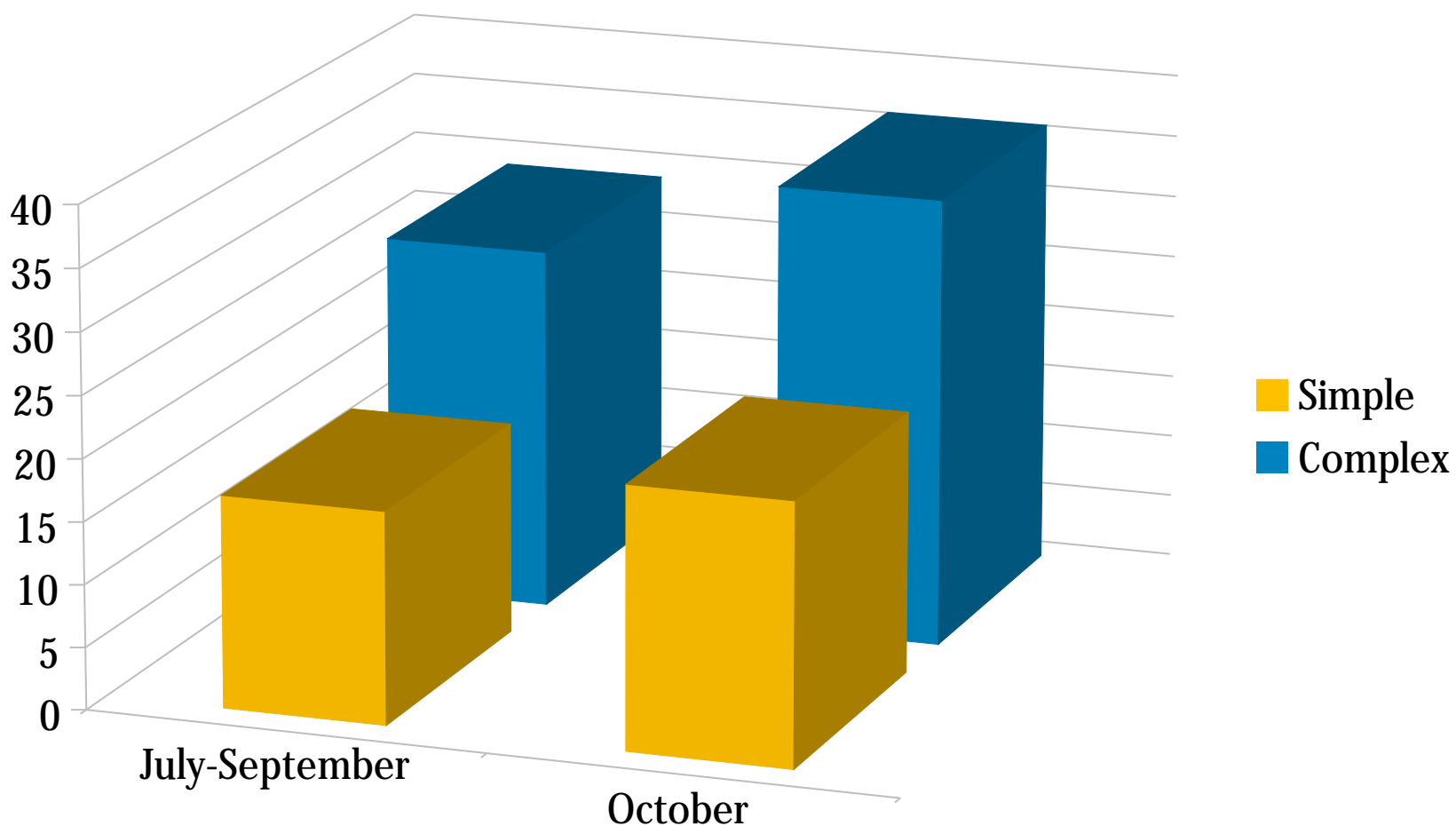
Congressional Responses Update

EXECSEC Congressional Responses Completed

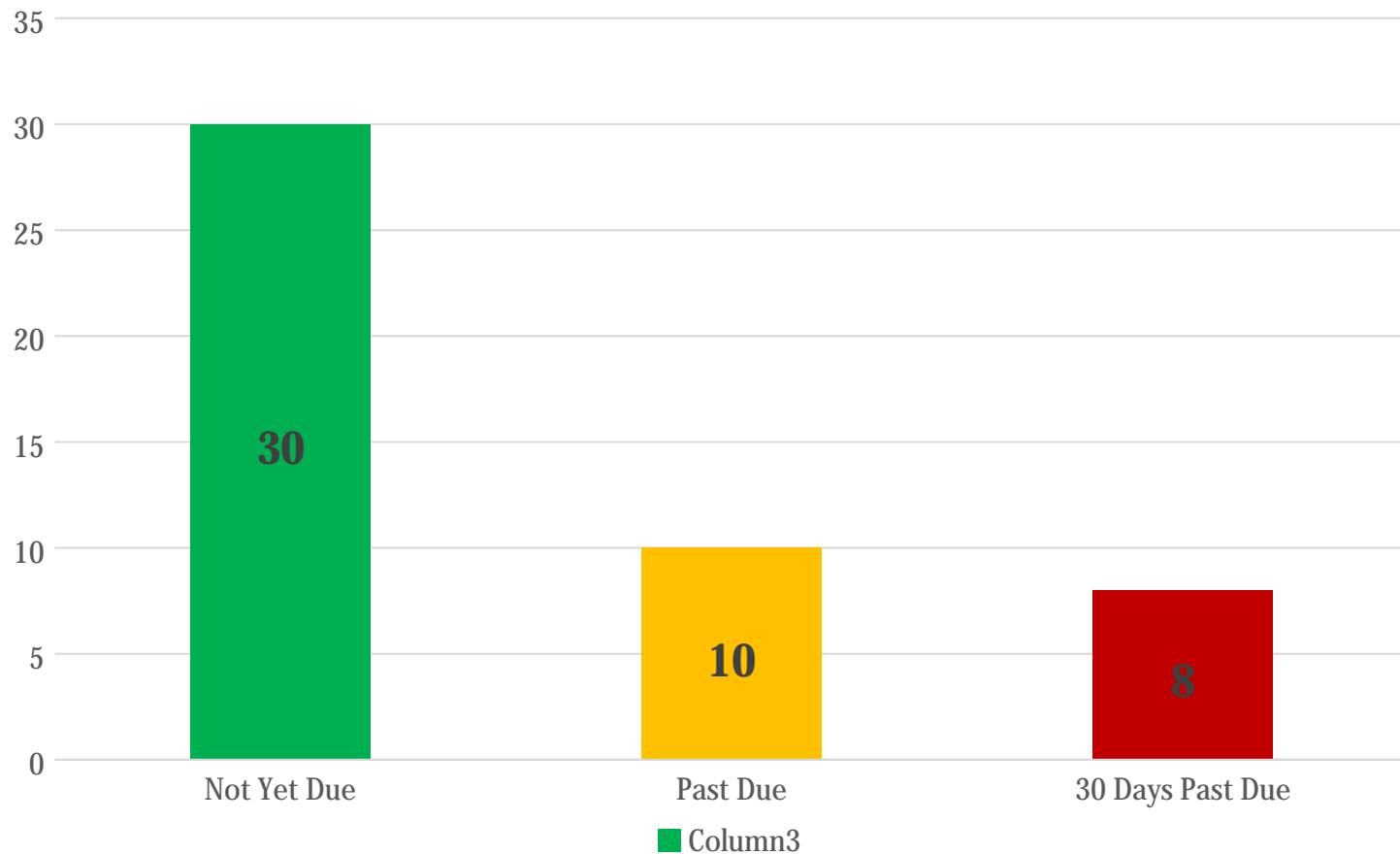


EXECSEC Congressional Responses - Average Days by Category

Average Days – Receipt to Signature Simple and Complex



EXECSEC Congressional Letters In-Work – As of November 9, 2018



CXO Updates

Chief Financial Officer

Overview

Purpose: Advise VA CFO on matters related to VA's overall financial management:

Collaborate to ensure financial priorities are consistent with VA's strategic goals and objectives.

Vet changes related to VA Financial Policy.

Last Session: November 1, 2018

New Focus: Deep Dive Sessions based on Council's preference

Updates

VA CFO Council Updates:

Deep Dive Topic: VA Reimbursables

Identified ways to improve overall accountability and timeliness of reimbursable funding agreements.

Realigned select reimbursements to Franchise Fund/BA.

Establishing Quarterly forum for customers/service providers.

Next Deep Dives:

VA Vacancies - HRSmart data

PIV Program Reimbursables

Chief Financial Officer

Primary Policies and Directives

Financial Policy Approvals: (five-year updates)
Volume I, Chapter 5 – Management Accountability and Responsibility for Internal Controls.
Volume II, Chapter 9 – Prior-Year Recovery.

Cancelled: VA's Travel Savings Award program
Implementation costs exceed travel saving benefits.
FY17: VA spent \$227M to save \$25K.

Risks

FY18 VA Financial Statement Audit:

End of Audit Meetings:
November 6, 2018 – Meeting with Clifton Larson Allen (CLA), OIG, and CFO stakeholders.
November 7, 2018 – Meeting with CLA, OIG, and SECVA.

Developing Corrective Action Plans (CAPs) for audit findings:
Initiating Financial Integrity Team (FIT) Program to support and lead proactive audit remediation.

Chief Information Officer

Overview

IT Governance Oversight Board (ITGB)-October 24, 2018

OIT Councils Supporting ITGB:

Program & Acquisition Review Council (PARC) met October 16, 2018.

Standards & Architecture Council (SAC) met October 22, 2018.

Organization & Workforce Council (OWC) met October 18, 2018.

Updates

IT Governance Oversight Board (ITGB) – October 24, 2018 (Next Meeting: December 2018):

PARC will research industry best practices and brief on incorporation of Cloud/Dev-Ops into the IT Governance Framework.

Analytics and Performance Management Committee (APMC) will develop specific CIO Governance Metrics for monthly review.

Standards and Architecture Council (SAC) – October 22, 2018:

Approved Enterprise Cybersecurity Strategy Program (ECSP) accountability plan for each Pillar.

Program and Acquisition Review Council (PARC) – October 16, 2018:

APMC to monitor major investments for risks, if risks are found, APMC will report to the Operations and Portfolio committee (OPMC) with recommendations for a TechSTAT Review. Budget, Planning and Acquisition Committee (BPAC) to perform an assessment of the Acquisition Review Module (ARM) threshold limits/ARM processes and provide recommendation on improving the tools acquisition tracking methods.

Chief Information Officer

Primary Policies and Directives

Key external policies guiding the Governance Oversight Board: Executive Order 13833: Enhancing the Effectiveness of Agency Chief Information Officers, FITARA, Clinger-Cohen Act of 1996, OMB Circular A-130, FISMA of 2014, Federal Managers' Financial Integrity Act (FMFIA), the Government Performance and Results Act Modernization Act of 2010 (GPRAMA), and National Institute of Standards and Technologies (NIST) Standards.

Working with OSP to address the Executive Order on Cyber Workforce.

Risks

Working through DoD/VA MedCOI MOU.
Working with VBA to address key issues on Colmery Act Sections Implementation.
Working to develop VHA's final 10 detailed business epics, which are delaying IT work on MISSION Act--three requirements are in progress. Working with OEI to accelerate Section 211 requirements.

Chief Acquisition Officer

Authority: Sec. 16A of the Office of Federal Procurement Policy (OFPP) Act, as amended, 41 U.S.C. 403, et seq.

Overview

Serves as principal interagency forum for monitoring and improving Federal acquisition system. Chaired by OMB's Deputy Director for Management; Vice-Chair selected by Council from among members; Members: Agency CAOs, Under Secretary of Defense for Acquisition, Logistics and Technology, and Senior Procurement Executives of each military department. The OFPP Administrator leads the Council on behalf of the Chair; administrative support is provided by GSA.

Meets every 3 months with ad hoc meetings as necessary.

Develops recommendations for the OMB Director on acquisition policies and requirements.

Assists the OFPP Administrator in identifying, developing and coordinating multi-agency improvement initiatives.

Furtheres integrity, fairness, competition, openness, and efficiency.

Appoints liaisons with Chief Information Officers Council, Chief Financial Officers Council, Human Resources Management Council, Small Business Procurement Advisory Council, and other councils or organizations, as appropriate.

Updates

Promotes effective business practices to ensure timely delivery of best value products & services and achieve public policy objectives.

Along with OPM, assesses and addresses hiring, training, and professional development needs of acquisition workforce.

Promotes President's Management Agenda in all aspects of acquisition system, as well as President's specific acquisition-related initiatives and policies.

Chief Acquisition Officer

Primary Policies and Directives

41 U.S.C.; codified in Federal Acquisition Regulation.

OMB Circular A-123, management's responsibility for Enterprise Risk Management and Internal Control.

Risks

Workforce attrition; aging workforce plus competition from commercial sector; mitigated by workforce investments.

Inefficient buying, effectively reduces federal capabilities; mitigated by application of "smart buying" best practices (a key Council focus).

Chief Acquisition Officer

Status of Recurring Reports to Key Stakeholders

Congressionally Mandated Reports

The two late CMRs represent Q3 and Q4 reports to Congress on Super Construction Projects. Q3 report awaits OM concurrence and Q4 awaits VHA and OM concurrences.

Q1 and Q2 were signed by SECVA on October 26, 2018.

GAO Priority Recommendations

GAO Report 17-70: VA CONSTRUCTION: Improved processes needed to monitor contract modifications, develop schedules, and estimate costs)

Per GAO: Recommendation #1 is closed as of October 10, 2018.

GAO Report 16-810: VA CONTRACTING: Improvements in policies and processes could yield cost savings and efficiency)

Currently being reviewed by GAO; awaiting GAO decision on OALC's closure request on recommendation #3.

Customer Experience Officer

CX Governance Board

Overview

Purpose: Hardwire insights and feedback from Veterans, their families, caregivers, and survivors into VA strategy and decision-making to inform and drive service recovery and performance improvement.

Participants:

Concurring Members – Under Secretaries, Chairman of Board, CVEO, CIO, and AS OPIA.

Consulted Members – All Assistant Secretaries

Board meet quarterly; Councils reporting to Board meet monthly.

Decision making process: Consensus – elevated to DEPSEC.

Elevation criteria: *Still under development.*

How decisions are communicated: *Still under development.*

Process to monitor implementation: Review of progress made by Councils reporting to Board.

Updates

Implementation of Secretary's Customer Service Policy.

Standing up Veterans Insight Council and expanding data reported to ensure enterprise decisions are powered by Veteran Signals.

Supports cross-cutting, Enterprise issues in alignment with PMA and A-11 such as Digital Modernization, Enterprise Contact Center standards and operations, Enterprise Outreach Strategy, and Service Recovery.

Pursuing Enterprise models of operations that are based in the VEO CX Framework and consistent with industry best practices.

Customer Experience Officer

CX Governance Board

Primary Policies and Directives

VA Customer Service Experience (CX) Policy was published August 22, 2018. Currently exploring the need for policies and directives in:

Digital domain requirements

Outreach

Service Recovery

Authoritative Data Sources with the Data Governance Council

Exploring opportunities to influence existing policies and directives with CX best practices.

Risks

CX Governance Board is planning the first meeting in early 2019:

Participation and support from concurrence members required to tackle difficult Enterprise decisions.

Timely establishment of the Veteran Insight Council:

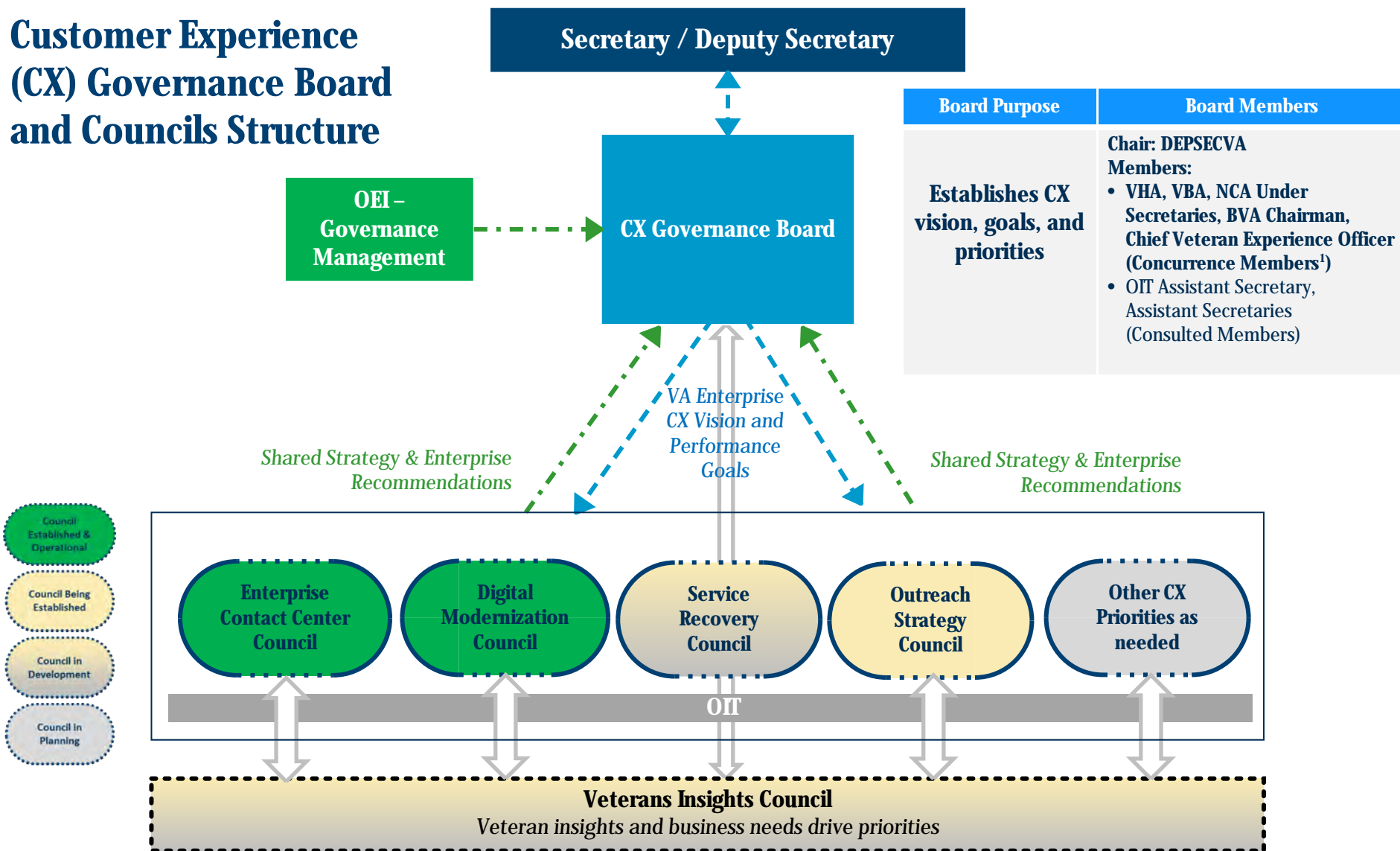
Support is needed in consolidating data stream inputs across the Enterprise to facilitate better decision-making.

IT UFR in FY19 Contact Center Modernization:

OIT will address the FY19 UFR.

Customer Experience Officer

Customer Experience (CX) Governance Board and Councils Structure



Chief Human Capital Officer

CHCOC

(Chief Human Capital
Officers Council)

Upcoming Events

Deputy CHCO Meeting (November 13, 2018)

Full Council Meeting (December 4, 2018)

Employee Engagement

President's Management Agenda

Priority Goal 3: Improve Performance Management and Engagement

20-20-20 Mandate (bottom 20% of the lowest scoring, level work units
by component/bureau)

Report Due November 15, 2018

Training Leaders

Upcoming Meeting

Next Meeting scheduled for December 5, 2018

No significant issues to report

DIVAC

(Diversity and Inclusion in
VA Council)

Membership Updates

Currently updating membership (VIEWS 117563)

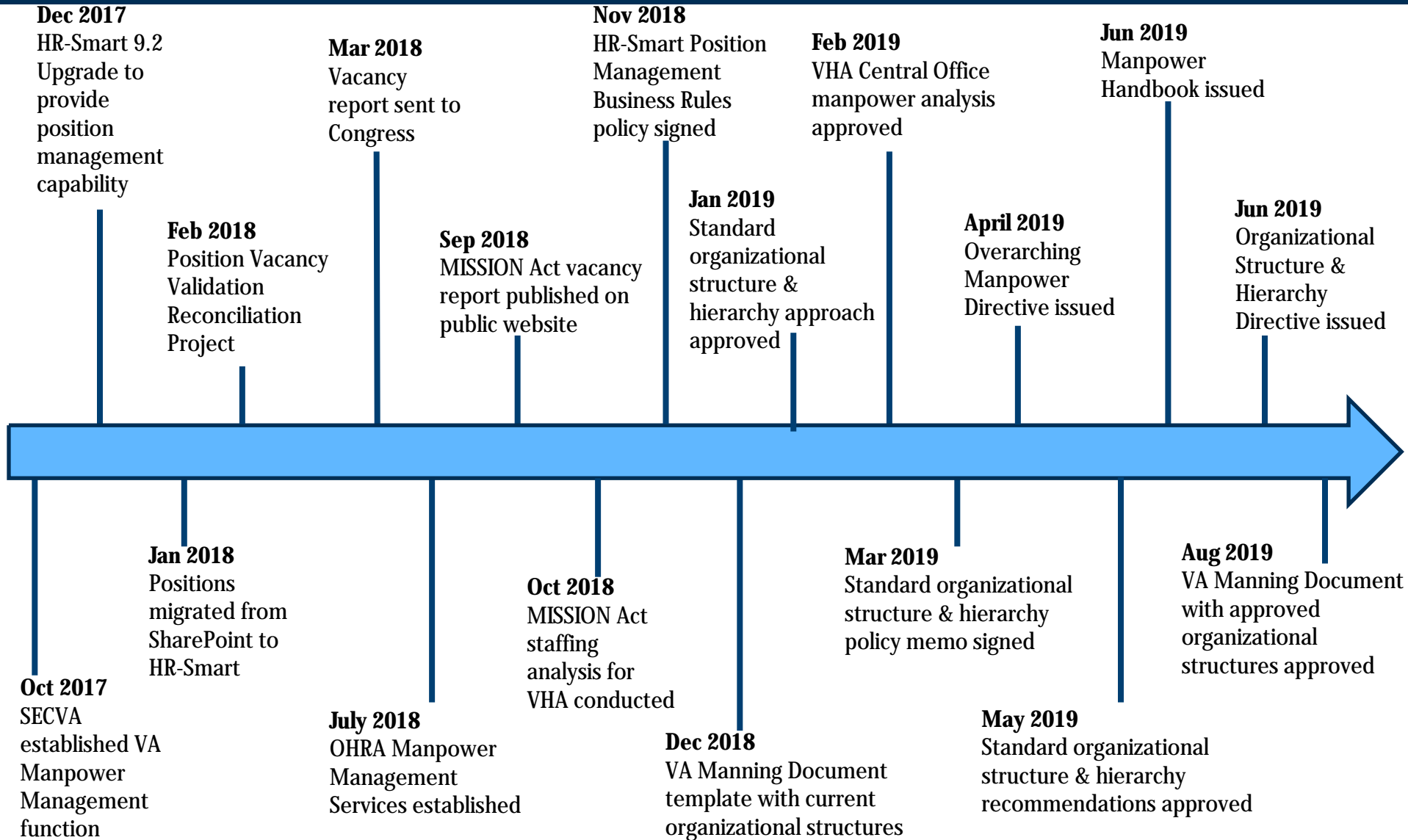
Next DIVAC Meeting scheduled for January 16, 2019

Management Deep Dives

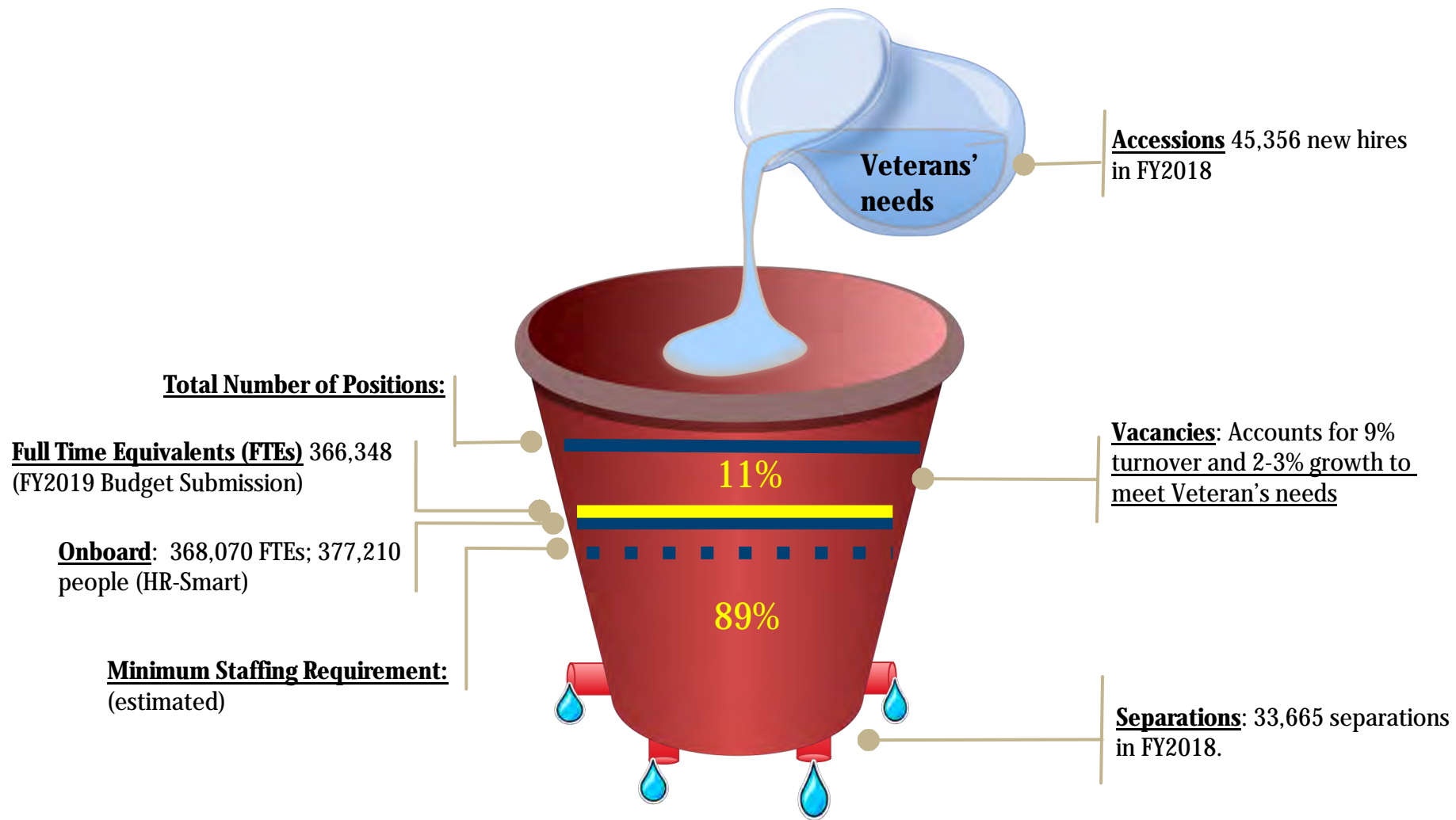
Human Resources and

Manpower Standards and Approach & Approach to Calculating Current Vacancies

Timeline to Manning Document



Flow of FTEs and Positions



Office of Accountability and Whistleblower Protection (OAWP) Policies and Operations

OAWP Metrics: Bottom Line Up Front (BLUF)

OAWP defines and manages work from a transactional process perspective.

- What:
 - Track work from receipt through resolution
 - Capture key hand-off's and milestones
- Why:
 - Provides staff and leadership a platform to discuss progress and growth in cases, FTE capacity, emerging trends or themes in submissions or case work
 - Enables constructive dialog around risks and issues as they arise – mitigate surprises

Key Performance Measures Include:

- Count Data: Incoming work, work processed; by type, by time period, by source, etc.
- Duration Data: Measure time in days between key events

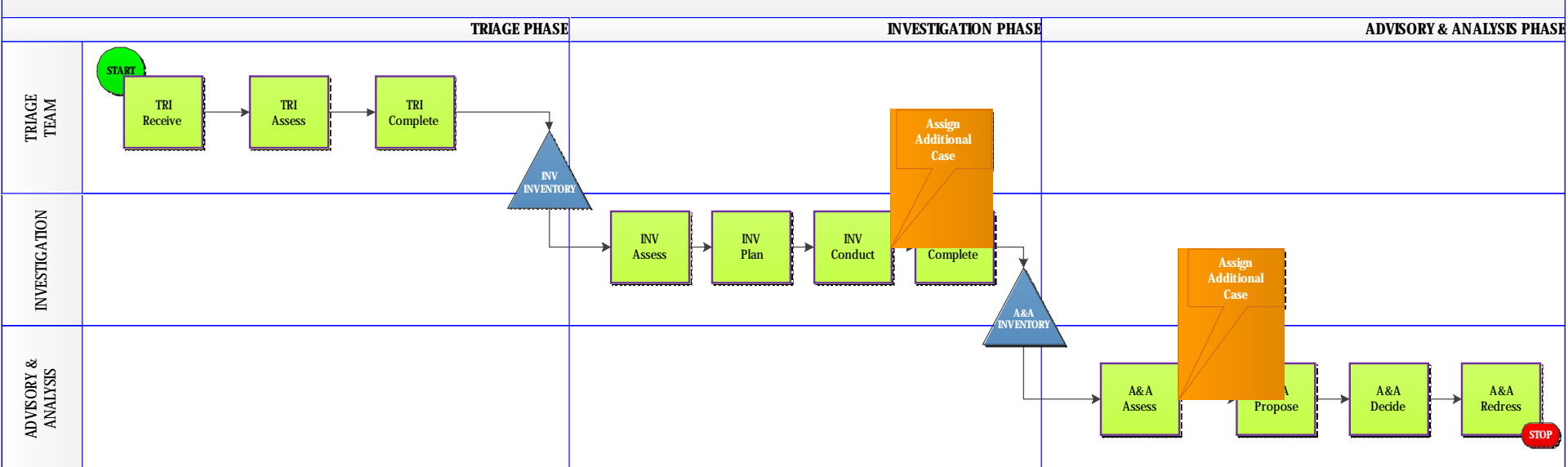
What's Next?

- Prepare Duration analysis
 - Process, policy and technology changes over time affect statistical relevance over time
 - Analyze data to identify statistically significant sub-populations of data in order to produce actionable duration analysis
- Use statistical control charts to assess process performance over time – in control or not? Differentiate between process noise and actual trends
- Assess repeatable performance and predict where process issues may arise

Process: OAWP-led Investigations

OAWP Summary Process & Metrics Map: OAWP INTERNAL INVESTIGATIONS

DATE OF MOST RECENT UPDATE 09 OCT 18



Map: Illustrates the high-level process for handling investigations and other matters within OAWP

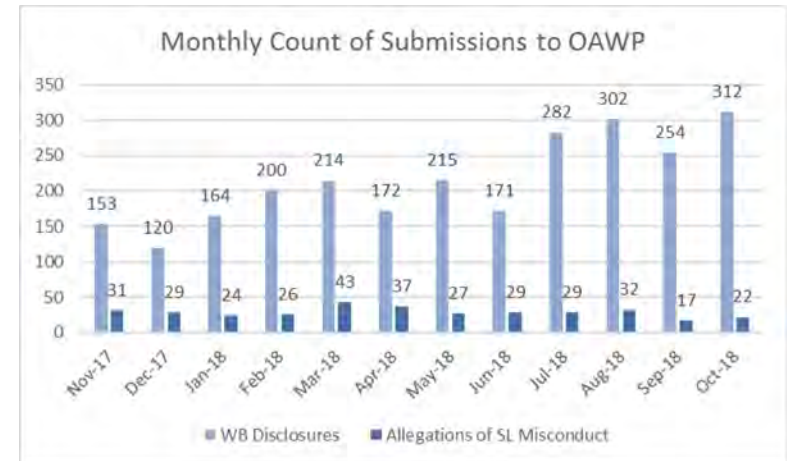
Metrics:

- Count: submissions passing through the process can be counted and monitored to ensure progress
- Duration: “ ” indicates where time stamps are taken to enable duration analysis

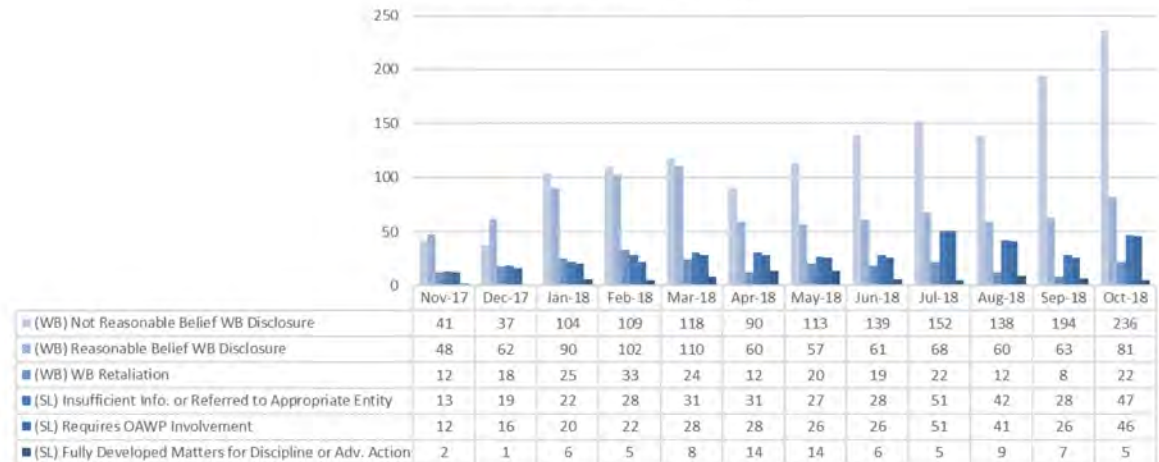
Count & Disposition of Submissions

WHAT: Count and Disposition of Submissions to OAWP

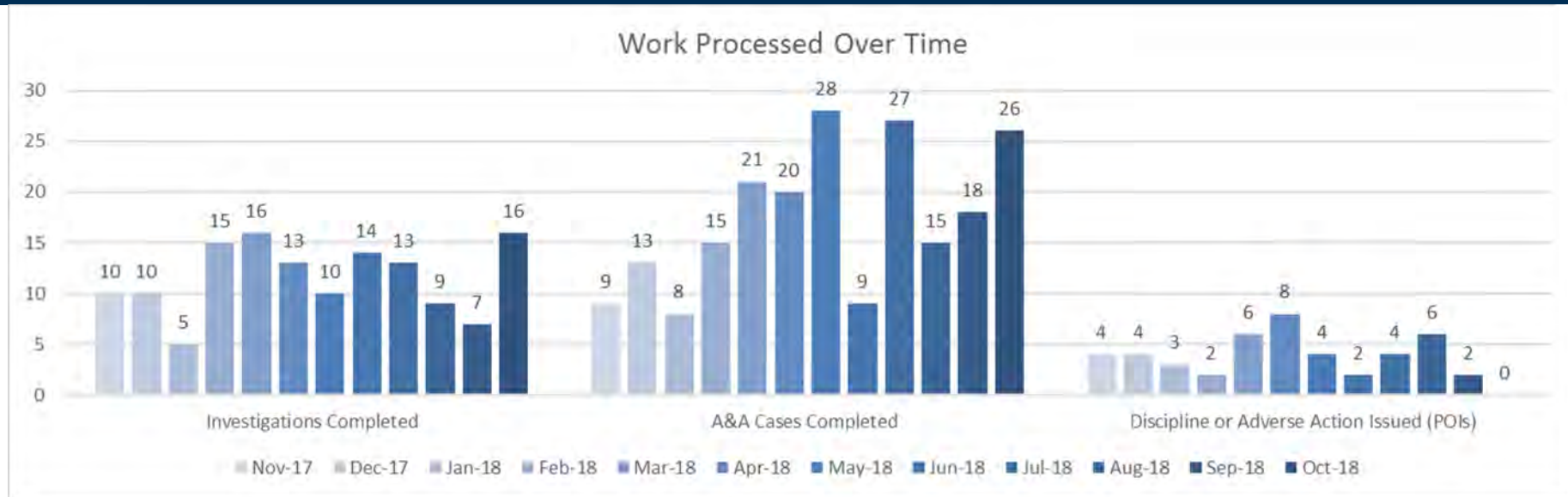
SO WHAT: Volume continues to grow across submission types



Disposition of Triaged Submissions

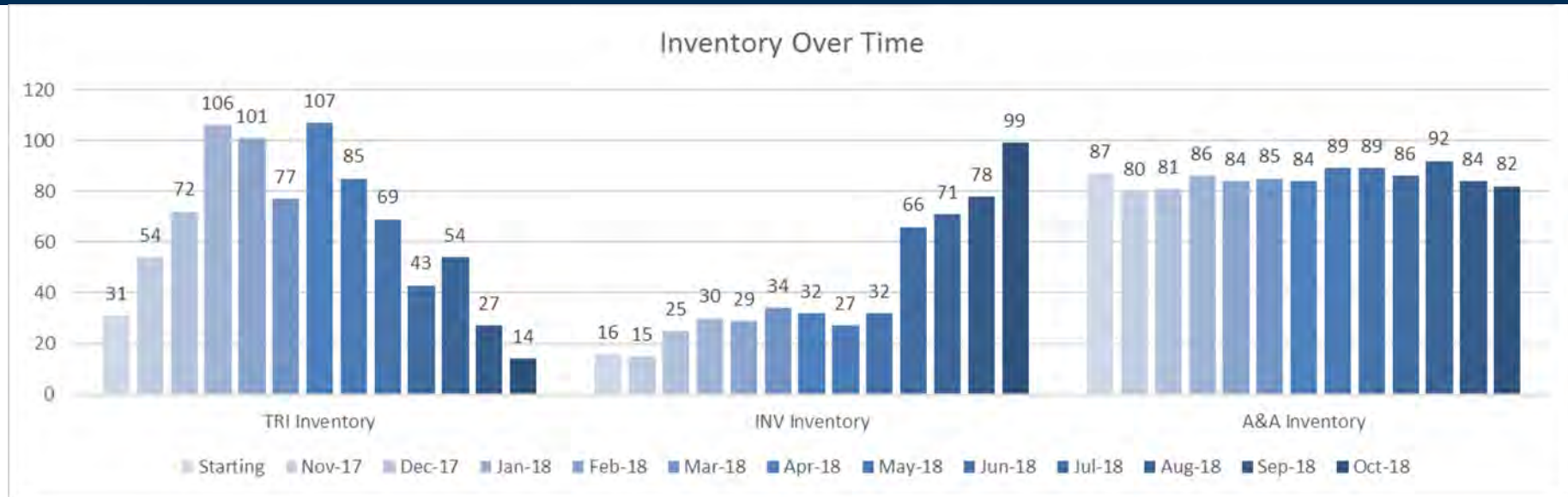


Count of Work Processed



- Concept for Illustration

Count of Inventory



NOTE: Concept for Illustration – data being refined for noise created by process changes during the period.

OAWP Emerging Policy & Process

OAWP Policy

Currently implementing directly from PL 115-41 and SecVA delegation February 2018

Revised SecVA delegation pending

- Adds “All GS-15 employees” to scope per SecVA testimony

- Delegates to AS, AWP authority to make determination of WB retaliation under 38 U.S.C. Section 731

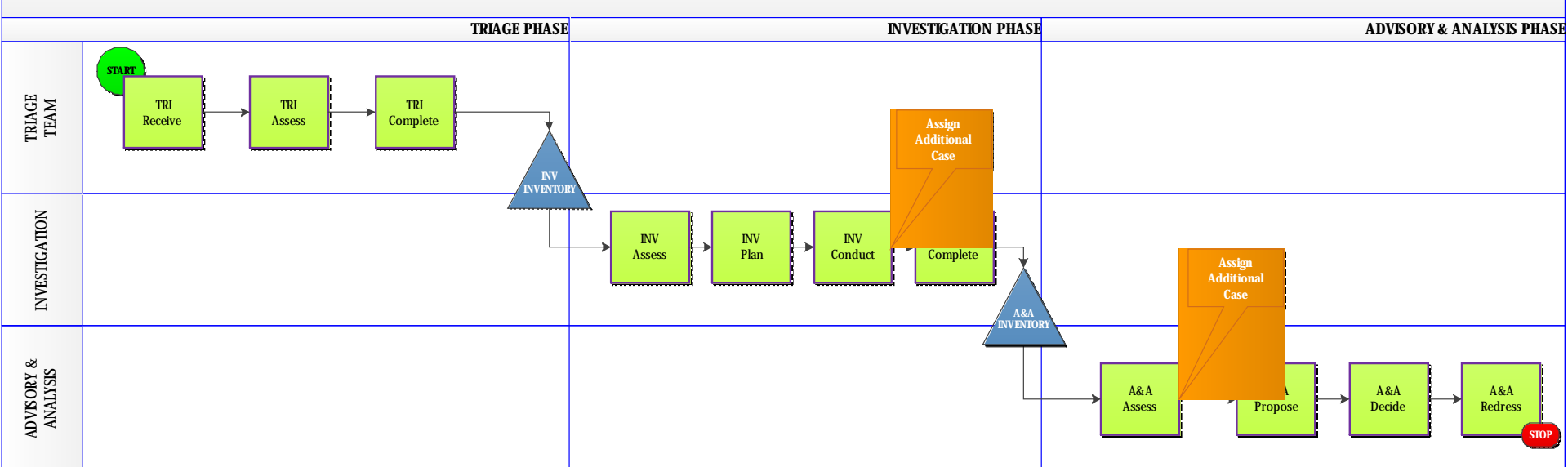
- Clarifies delegation of all items from 38 U.S.C. Section 323 to Executive Director, OAWP until AS appointed

OAWP Directive drafted, pending internal OAWP review/concurrence

Process: OAWP-led Investigations

OAWP Summary Process & Metrics Map: OAWP INTERNAL INVESTIGATIONS

DATE OF MOST RECENT UPDATE 09 OCT 18



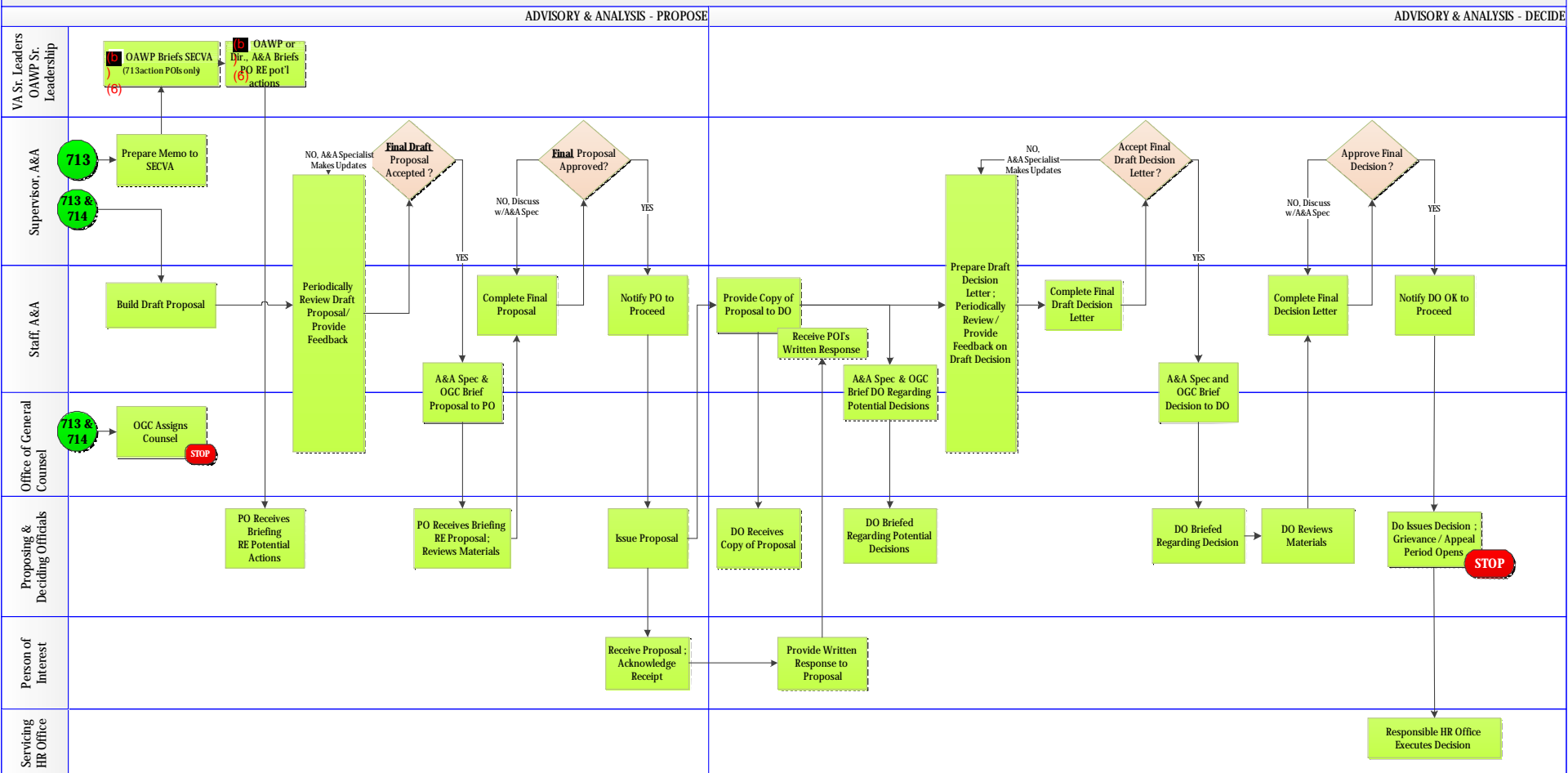
Map: Illustrates the high-level process for handling investigations and other matters within OAWP

Metrics:

- Count: submissions passing through the process can be counted and monitored to ensure progress
- Duration: “ indicates where time stamps are taken to enable duration analysis

Process: Propose-Decide

OAWP Process Map: **ADVISORY & ANALYSIS - PROPOSE**
DATE OF MOST RECENT UPDATE 09 OCT 18



- Several hand-off's and review points slow progress
- Joint steps can be difficult to coordinate (e.g., briefings to PO, DO)

Work In Process (WIP)

OAWP High-level Process Summary with FY18 Summary Data Data As Of: 06 NOV 18

FY18 Data:

97: Average Days (Straight to A&A)
165: Average Days (OAWP In-Person Investigation)
176: Average Days (OAWP Virtual Investigation)
96: Average Days (External Investigation)

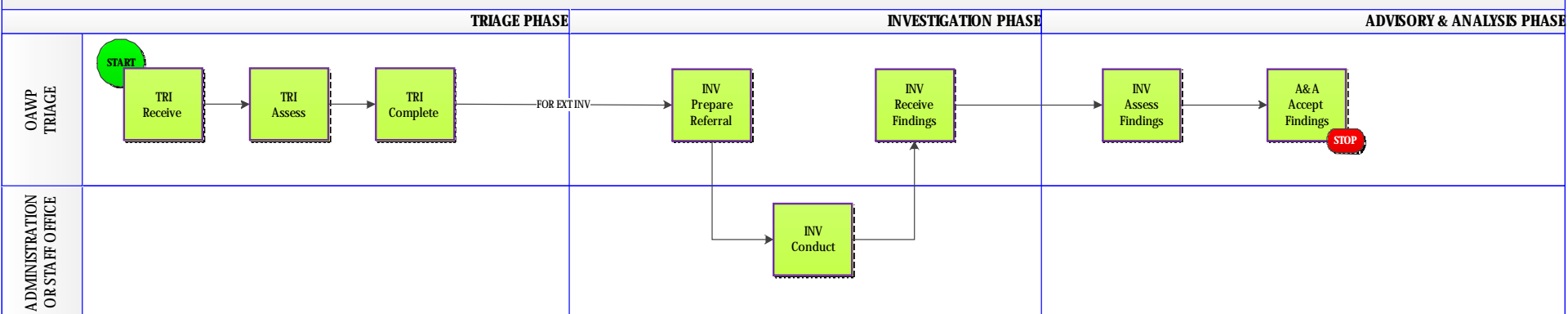
	TRIAGE	INVESTIGATION	ADVISORY & ANALYSIS
Work In Process (WIP)	351: Submissions in Triage (Open & On-Hold Items)	81: Matters in OAWP Investigation Inventory 83: Matters Being Investigated by OAWP 213: Matters Currently Referred to Another Entity for Investigation	1: Matters in OAWP Advisory & Analysis Inventory 53: Matters Being Assessed 38: POIs Being Assessed Disciplinary or Adverse Action
Work Completed Period FY18 Q4	854: Submissions Received 692: Submissions Triaged	99: Matters for OAWP Investigation 29: Investigations Completed by OAWP * 90: Matters Referred to Another Entity for WB Investigation 100: WB Investigations Completed by Another Entity * *Some investigations completed in the period started prior to the period.	49: Matters for OAWP A&A Assessment (includes "Straight to A & A" matters) 60: Matters Assessed for Potential Disciplinary or Adverse Action 14: Matters Resulted in an Action Recommendation for one or more POIs 20: POIs with Discipline or Adverse Action Recommended XX: POIs with Discipline of Adverse Action Issued 116: Referred Matters with Findings Accepted by OAWP
Durations Period FY18	NA: Average Days in Inventory 48: Average Days to Complete (SL Misconduct) 21: Average Days to Complete (WB Disclosures)	19: Average Days in Inventory (OAWP Investigations) 79: Average Days to Complete (OAWP Investigations) 87: Average Days to Complete (Investigations referred outside of OAWP) *Some investigations completed in the period started prior to the period.	16: Average Days in Inventory (Straight to A&A) 13: Average Days in Inventory (OAWP Investigation) 34: Average Days to Complete "Assess" (Straight to A&A + OAWP Investigation) 70: Average Days "Assess Complete" to "Discipline Issued" (Straight to A&A + OAWP Investigation)
OAWP Capacity	FTE: 19 Triage Specialists (authorized 20) Capacity (point in time): * TBD/ specialist (Standard) (being assessed now) * TBD/ specialist (Standard) (being assessed now)	FTE: 27 Investigators/ HR Specialists Capacity (point in time; across Assess-Plan-Conduct): * 2-3 cases/ investigator (Standard) * 4-5 cases/ investigator (Surge) (for limited time or complexity) * 54-81 cases/ OAWP (Standard)	FTE: 10 HR Specialists Capacity (point in time): * 2 cases/ specialist (Standard) (each case may have one or more POIs) * 4 cases/ specialist (Surge) (each case may have one or more POIs) * 20 cases/ OAWP (Standard)

- Investigations Inventory is growing quickly due to policy change to direct all retaliation investigations to OAWP investigators

Process: Admin/Staff Office-led Investigations

OAWP Summary Process & Metrics Map: EXTERNAL INVESTIGATIONS(WB Disclosures for Administration or Staff Office Investigation)

DATE OF MOST RECENT UPDATE 09 OCT 18



All disclosures submitted to OAWP are assessed

Reasonable belief matters are referred for investigation (either to OAWP investigators or respective Admin/ Staff Office); OAWP receives findings and assesses outcomes

Some submissions are not WB related, and are referred to the appropriate Admin/Staff Office for review and response directly to the disclosing party (e.g., safety concerns, Veteran or family member inquiries, etc.)

IT UFR Process and Current Integrated Priority List

Unfunded Requirement (UFR) Process

UFR Process

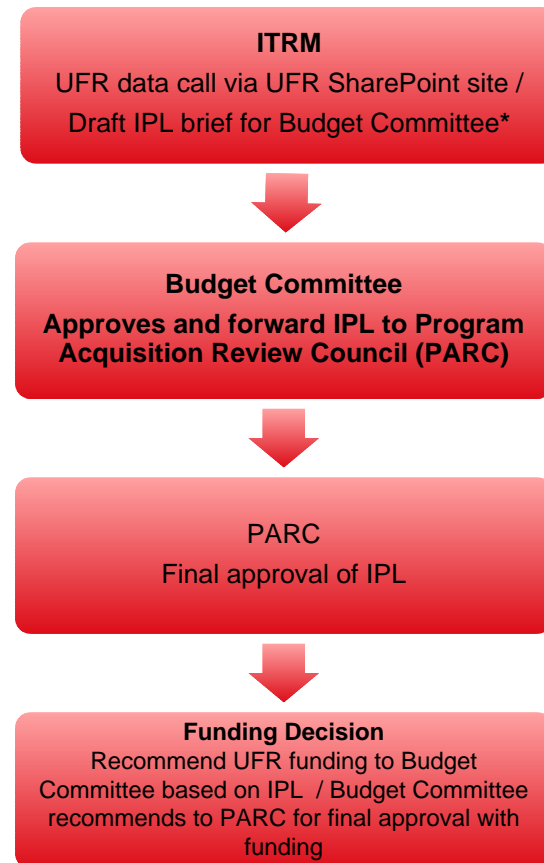
Series of actions which identifies unfunded projects, to be executable in the current fiscal year, that could be supported if funding becomes available.

Objective of the UFR Process: To create an Integrated Priority List (IPL) of UFRs.

Implementation of UFR Process: OIT Chief Financial Officer (CFO) determines there are sufficient funds to support additional projects that were not originally included in the Budget Operating Plan.

Outcome of the UFR Process: An unfunded IPL that is vetted and approved via the UFR Prioritization Working Group and OIT governance structure resulting in a funding decision (see IPL Process).

Unfunded Integrated Priority List (IPL) Process



**For FY19: Initial data call to submit UFRs will occur in Q1 (or as soon as policy is approved) for the upcoming Fiscal Year*

VA Operational Planning Office of Enterprise Integration

VA Operational Planning & Governance

Problem Statement: VA is currently unable to understand, measure, or manage successful achievement of the SECVA Priorities or effectively respond to emerging external requirements.

Objective: Leverage the Emerging Governance Structure and Processes to:

- Establish Planning Standards for VA Programs and Initiatives

- Document Intended Outcomes

- Create Measurable Objectives

- Enable Performance Improvement

- Drive Accountability

OEI's role:

- Establish Program Planning Standards

- Coordinate support for Programs and Initiatives

- Support identification and resolution of critical needs and/or operational issues

- Address systemic management and execution issues

- Support leaders in effectively managing their Programs and Initiatives

Intended Outcome:

- Create greater transparency for VA senior leadership regarding progress against achieving SECVA Priorities.

- Enhanced execution of Programs and Initiatives by surfacing and resolving issues impeding progress.

FY19 Operational Plans Candidates (1 of 2)

VHA

Mission Act

Community Care consolidation
 Telehealth expansion
 Caregiver compensation expansion
 Assessment of Infrastructure and Resources

Mental Health

Filling MCOs for Mental Health
 Implementing National Suicide Prevention EO

VHA Modernization

Supply Chain (Business Transformation)

Modernizing VHA supply chain*

VHA (cont)

Geographically Underserved Populations
 Infrastructure gaps
 Providing Healthcare
 Mental Healthcare

VBA

Forever GI Bill*

Office of Transition and Economic Development milestones

BVA

Appeals Modernization*

NCA

Assumption of Veteran Cemeteries from DoD

* OEI will consolidate existing plans into Plan Format

FY19 Operational Plans Candidates (2 of 2)

OEI & OIT

Business requirements integration

Data integration

OIT

Interoperability of VA between Commercial
Care Provider IT Systems

OHRM

Manpower plan

Filling Mission Critical Occupations (MCOs)

EHRM

Execution plan

OAWP

Holding Executive leadership accountable

Establishment of roles and functions between
OWAP, Internal Controls, OGC, OIG

OM

Stop Fraud, Waste, and Abuse*

OALC

TBD (Business Transformation)

VEO

Veteran Experience Strategy implementation

Woman Veteran Equities

Providing Healthcare

Ending Homelessness

Improving Employment

Providing Mental Healthcare

* OEI will consolidate existing plans into common plan format

Operational Plan - Essential Elements of Information

Organizational or Program Mission

Vision Statement

Program Owner & Program Organizational Structure

Program/Initiative Objectives and measurable outcome targets

- Schedule (activities sequenced) and Milestones

- Customer Service Improvement Elements/Targets

- Performance Measures (baseline, goals, and stretch goals)

Resources

- Staffing Plan (Gov't FTE)

- Contract Support Requirements

- IT Requirements

- Acquisition Strategy

- Resource Gaps (if applicable) and impact on Performance Measures

- Dependencies

Risks/Issues & Mitigation Strategies

VA Operational Planning Model

Action	SECVA/ DEPSEC/ COSVA	Plan Owners	Staff Offices (Enabling Support)	Governance Board	Office of Enterprise Integration
Planning Standards				VAOB	✓
Program/Initiative Selection & Annual Objectives Refresh	✓			VAEB	
Operational Plan Development		✓	✓	VAOB	
Quality Assurance				VAOB	✓
Operational Plan Execution		✓	✓	VAOB	
Performance Management & Oversight				VAEB (Quarterly) VAOB (Monthly)	✓
Issue Resolution	✓			VAEB	

Back Up Slides

Enterprise Governance Bodies

Chair

SECVA

SECVA Stand-up (Meets Daily)

- Brief SECVA on key daily issues

Management Synchronization Meeting (Meets Weekly)

- Major near-term (30-day) milestones
Key issues and immediate Secretary decisions

VA Executive Board (VAEB) (Meets quarterly or as needed)

- VA strategy, policy, major investments

Under Secretaries Meeting (Meets Weekly)

- Execution priorities and strategic planning

VA Operations Board (Meets Bi-Monthly)

- Reviews budget execution, operations and performance; OIG/GAO high risk and issue management

Modernization Board (Meets Monthly (or as needed))

- Reviews performance and execution of VA Modernization initiatives/priorities & reform efforts

Mission Act Enterprise Program Execution Reviews (Meets Weekly/As Needed)

- Detailed updates (cost, schedule and performance) of targeted initiatives

EHRM Enterprise Program Execution Reviews (Meets Weekly/As Needed)

- Detailed updates (cost, schedule and performance) of targeted initiatives

President's Management Council* (Meets Quarterly)

- Oversees implementation of government-wide management policies/programs

Joint Executive Committee* (Meets Quarterly)

- Recommends strategic direction for the joint VA/DOD coordination/sharing
- Co-chaired by SECVA semi-annually
- Bi-monthly touchpoints with DOD

COSVA

Chief of Staff Council Meeting (Meets Weekly)

Manages execution of decisions made from other boards

AS/US/ Exec. Dir

Administration Governance
Bodies

CXO Governance Bodies

Strategic

Execution

Synchronization

*External Cross-Government bodies managed by the DEPSECVA

OGC POCs

Financial Management Business Transformation

Procurement Law Group SMEs: Bob Fleck and (b) (6) (PrLG);

The FMBT program (the purpose of which is to modernize the VA's legacy Financial Management System) was originally a procurement being administered by the United States Department of Agriculture (USDA) as a shared service, but USDA in December 2017 notified VA that it would no longer be the Federal Shared Service provider and VA was required to take over administration of all USDA awarded task orders. Accordingly, OGC has to provide guidance on transferring software licenses, terminating certain software licenses, acquiring new software licensing, modifying contracts, and awarding four new contracts (the awarded contracts ranged from \$12 million to \$750 million) in a compressed period of time in order to ensure the FMBT program continued without interruption.

Secondarily, involved through contracts supporting supply chain management objectives including the JEC, Joint Executive Counsel a DoD/ VA committee to support collaboration in efforts to provide medical care and share resources, routinely releases objectives requiring support from both PrLG. Most recent FY17/18 was the use of "ECat" a DoD interface which allows for an assisted acquisition to DoD.

Revenue Law Group SMEs: (b) (6) and (b) (6)

Supply Chain Transformation

Procurement Law Group SMEs: Bob Fleck and (b) (6) (PrLG)

Involved via procurement of follow on contract for commodities Medical Surgical Prime Vendor. PrLG has supported this effort over the last decade, and since FY16 also supported the NexGen approach and the 2.0. Currently working with OAL and VHA leadership and acquisitions to identify sources and coordination of efforts. Multiple inquiries by HVAC and SVAC as well as industry. Some litigation regarding the execution was resolved in September (Electra-Med matter).

Telehealth

Health Care Law Group SME: (b) (6) (this issue also involves the Personnel Law Group)

- Provided technical assistance for MISSION Act legislation
- Reviewed regulation that preceded MISSION Act legislation
- Addressing questions concerning prescribing of controlled substances
- Providing guidance on legal questions presented by program

Procurement Law Group SMEs: Bob Fleck and (b) (6) (PrLG);

Review of the contracts underlying the COTs and cloud services to ensure that execution of the project. Our office worked in FY16/17 to ensure that all items on contract were in scope. As an IDIQ additional work will be needed over the contract life cycle.

Information Law Group SME: (b) (6)
data governance and security issues.

Personnel Law Group SME: (b) (6) with (b) (6) and (b) (6)

assisted in developing regulations and working w VHA on anywhere-to-anywhere initiative (allowing VA providers who are not providing telehealth to allow them to provide services anywhere as long as its within their scope of practice).

OGC POCs

STOP Fraud, Waste and Abuse

Health Care Law Group SME: (b) (6) (Medicare data)

Participating in discussions about how this information may be used in future community care program.

(b) (6) -Participated in a discussion with ILG concerning current ability to use information from CMS.

Procurement Law Group SME: Bob Fleck and (b) (6)

Involved through Federal Acquisition Regulation (FAR) requirements (3 and 9.4) for procurement integrity as well as avoidance of conflict of interest.

This includes work of attorneys in specific contract matters as well as our Debarment and Suspension support.

Personnel Law Group SME: (b) (6)

advised on whether they can hire investigators (yes) and advising on follow-up issues on info sharing related to investigator findings.

Navigator Customer Experience

Not available

HR Modernization

Personnel Law Group SME: (b) (6)

met with them back in January but haven't heard anything from them since.

Appeals Modernization

Benefits Law Group SME: (b) (6)

Has worked closely with BVA and multiple VBA program offices to implement the Appeals Modernization Act.

Assisted in coordinating and reconciling inputs from multiple offices into a comprehensive proposed rule adding or revising more than 150 CFR sections.

Assisted VBA and BVA in implementing pilot programs to test aspects of the modernized appeals system.

Assisting in analyzing comments on proposed rule, developing responses for final rule notice.

Health Care Law Group – Lead SME: (b) (6) (HCLG has other SME's working with particular VHA Programs)

Working with VHA to help them understand requirements of the Appeals Modernization Act and how that will impact individual programs.

Working with VHA programs on developing templates for notices of decisions.

Working with VHA to develop interim final rule.

OGC POCs

Forever GI Bill

Benefits Law Group SME: (b) (6)

Provided Education Service advice regarding statutory interpretation.

Has been reviewing Education Service's preliminary drafts of the proposed rulemaking.

Procurement Law Group SMEs: Bob Fleck and (b) (6)

PrLG has supported VBA in revising the contracts supporting these programs. We have also advised regarding endorsements.

Mental Health Joint Action Plan

Health Care Law Group SMEs: (b) (6)

Providing legal guidance on VA's authorities to provide treatment

Providing legal review of materials developed for the initiative

Electronic Health Record Modernization (EHRM)

Procurement Law Group SMEs: Bob Fleck and (b) (6)

OGC was heavily involved in crafting the public interest determination and findings (D&F) the allowed a sole-source firm-fixed-price approximately \$10 Billion, Indefinite Delivery/Indefinite Quantity (ID/IQ) contract to Cerner to acquire the EHR system being deployed by the Department of Defense (DoD) and related services for deployment and transition across the VA enterprise in a manner that meets VA needs enabling seamless healthcare to Veterans and qualified beneficiaries. OGC was instrumental in supporting this award throughout all aspects of the program, from the pre-award contract negotiation, contract and multiple task order awards, and successful defense of bid protest challenges at the Agency and Federal Court level.

Personnel Law Group SMEs: (b) (6) and (b) (6)

hiring staff as T38 providers and helped draft legislation to accomplish this and advised on interim process with dotted line authority to allow T38 pay retention.

MISSION Act

Health Care Law Group SME's:

Community Care – (b) (6)

Caregivers – (b) (6)

Providing legal guidance on MISSION Act provisions to facilitate decision-making

Assisting in the drafting and development of necessary regulations implementing the law

Legal review of regulations

Personnel Law Group SME: (b) (6) and (b) (6)

podiatrist pay to ensure its similar to physician pay (b) (6) also advising on education programs (b) (6)

Monthly Execution Review (MER) – Congressional Reports

Data as of September 2018

Office of Budget				
Congressional Reports Pending as of October 24, 2018				
64 Overdue and 32 Coming Due on October 30, 2018 or later				
	LEGEND:	Reports Overdue	Reports Coming Due	Reports Completed
Report Topic	Responsible Organization	Date Due to Budget Office	Date Due to Congress	Date to Hill
Encouraging Public-Private Partnerships - 1st Q tr.	CFM	1/16/2018	1/30/2018	
National Outreach and Awareness Marketing Campaign - 1st Q tr.	OPIA	1/16/2018	1/30/2018	
Small, minority-and women-owned businesses - 1st Q tr.	OSVA	1/16/2018	1/30/2018	
Quarterly reporting - Major Construction - 1st Q tr.	OALC/CFM	1/16/2018	1/30/2018	
Appointment scheduling system	OIT	4/9/2018	4/23/2018	
Veterans data protection	OIT	4/9/2018	4/23/2018	
Spending plan	VHA	4/9/2018	4/23/2018	
Encouraging Public-Private Partnerships - 2nd Q tr.	CFM	4/16/2018	4/30/2018	
National Outreach and Awareness Marketing Campaign - 2nd Q tr.	OPIA	4/16/2018	4/30/2018	
Small, minority-and women-owned businesses - 2nd Q tr.	OSVA	4/16/2018	4/30/2018	
Quarterly reporting - Major Construction - 2nd Q tr.	OALC/CFM	4/16/2018	4/30/2018	
Central office responsiveness	OCLA	4/16/2018	4/30/2018	
West Los Angeles, California seismic corrections	CFM/OAEM	5/9/2018	5/23/2018	
Bakersfield outpatient clinic	CFM	5/9/2018	5/23/2018	
White House Veterans Complaint Hotline	VEO	5/9/2018	5/23/2018	
Hiring delays	VHA	5/9/2018	5/23/2018	
Kingdomware Decision	OIT	5/9/2018	5/23/2018	
Cybersecurity	OIT	5/9/2018	5/23/2018	
Rare cancers	VHA	6/8/2018	6/22/2018	
Improving Federal Burn Pits Registry	VHA	6/8/2018	6/22/2018	
Women's access to medical services	CFM	6/8/2018	6/22/2018	
Delayed provider payments	VHA	6/8/2018	6/22/2018	
Bakersfield outpatient clinic	CFM	7/9/2018	7/23/2018	
Financial Management and Health Care Delivery	VHA	7/9/2018	7/23/2018	
Mental health services training for community providers	VHA	7/9/2018	7/23/2018	
Position vacancies	VHA	7/9/2018	7/23/2018	
Rural caregivers	VHA	7/9/2018	7/23/2018	
Encouraging Public-Private Partnerships - 3rd Q tr.	CFM	7/16/2018	7/30/2018	
Long-Term Care - 3rd Q tr.	VHA	7/16/2018	7/30/2018	
Central office responsiveness - 3rd Q tr.	OCLA	7/16/2018	7/30/2018	
National Outreach and Awareness Marketing Campaign - 3rd Q tr.	OPIA	7/16/2018	7/30/2018	
Small, minority-and women-owned businesses - 3rd Q tr.	OSVA	7/16/2018	7/30/2018	

Monthly Execution Review (MER) – Congressional Reports

Data as of September 2018

Congressional Reports Pending as of October 24, 2018				
64 Overdue and 32 Coming Due on October 30, 2018 or later				
	LEGEND:	Reports Overdue	Reports Coming Due	Reports Completed
Report Topic	Responsible Organization	Date Due to Budget Office	Date Due to Congress	Date to Hill
Quarterly reporting - Major Construction -3rd Q tr.	O A L C / C F M	7/16/2018	7/30/2018	
High-cost areas	V H A	9/7/2018	9/21/2018	
Women's health	V H A	9/7/2018	9/21/2018	
Corporate Planning and High Performing Networks	V H A	9/7/2018	9/21/2018	
Corporate Planning and High Performing Networks	V H A	9/7/2018	9/21/2018	
National Center for Post-Traumatic Stress Disorder	V H A	9/7/2018	9/21/2018	
Treatment for Post-Traumatic Stress Disorder	V H A	9/7/2018	9/21/2018	
Opioid Safety	V H A	9/7/2018	9/21/2018	
Opioid Addiction Treatment Protocols	V H A	9/7/2018	9/21/2018	
Dependents and Prescription Drug Monitoring Programs	V H A	9/7/2018	9/21/2018	
Orthotics and Prosthetics Workforce	V H A	9/7/2018	9/21/2018	
DoD and V A Prescription Drug Purchasing	V H A	9/7/2018	9/21/2018	
Center for Compassionate Innovation	V H A	9/7/2018	9/21/2018	
Hospice Care	V H A	9/7/2018	9/21/2018	
Home and Community Based Services	V H A	9/7/2018	9/21/2018	
Burn Pits Research	V H A	9/7/2018	9/21/2018	
Filling Vacant Positions	H R A	9/7/2018	9/21/2018	
Construction Contracting Outreach	C F M	9/7/2018	9/21/2018	
Medical staff retention	V H A	9/7/2018	9/21/2018	
Management reforms	O P P	9/7/2018	9/21/2018	
Legacy system decommissioning plan	O I T	9/7/2018	9/21/2018	
Veterans Service Centers	V B A / V H A	9/14/2018	9/28/2018	
Financial Hardship and Bankruptcy	O G C	9/14/2018	9/28/2018	
Rural Veterans Coordination Pilot	V H A	9/14/2018	9/28/2018	
Assessing Homelessness in Rural Areas	V H A	9/14/2018	9/28/2018	
Prescription Drug Monitoring Program Utility	V H A	9/14/2018	9/28/2018	
National Center for Posttraumatic Stress Disorder (PTSD)	V H A	9/14/2018	9/28/2018	
Postpartum depression	V H A	9/14/2018	9/28/2018	
H U D - V A S H program	V H A	9/14/2018	9/28/2018	
Maternity care benefit, survey, and education campaign	V H A	9/14/2018	9/28/2018	
Training for V A personnel engaged in facility management	C F M	9/14/2018	9/28/2018	
Deferred maintenance	N C A	9/14/2018	9/28/2018	

Monthly Execution Review (MER) – Congressional Reports

Data as of September 2018

Congressional Reports Pending as of October 24, 2018				
64 Overdue and 32 Coming Due on October 30, 2018 or later				
	LEGEND:	Reports Overdue	Reports Coming Due	Reports Completed
Report Topic	Responsible Organization	Date Due to Budget Office	Date Due to Congress	Date to Hill
Filling Vacant Positions	HRA	10/16/2018	10/30/2018	
Caregivers program - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Hepatitis C Treatment - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Encouraging Public-Private Partnerships - 4th Q tr.	CFM	10/16/2018	10/30/2018	
Long-Term Care - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Veterans Health Administration - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Claims Processing - 4th Q tr.	VBA	10/16/2018	10/30/2018	
Central office responsiveness - 4th Q tr.	OCLA	10/16/2018	10/30/2018	
Performance reporting - September	VBA	10/16/2018	10/30/2018	
Disability Claims Processing - September	VBA	10/16/2018	10/30/2018	
OIT Expenditure Plan - September	OIT	10/16/2018	10/30/2018	
Disability Claims - 4th Q tr.	BVA	10/16/2018	10/30/2018	
Disability Claims - 4th Q tr.	VBA	10/16/2018	10/30/2018	
National Outreach and Awareness Marketing Campaign - 4th Q tr.	OPIA	10/16/2018	10/30/2018	
Small, minority-and women-owned businesses - 4th Q tr.	OSVA	10/16/2018	10/30/2018	
Quarterly reporting - VHA - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Quarterly reporting - Choice Act - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Quarterly reporting - Hep C - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Quarterly reporting - Transfers - 4th Q tr.	VHA	10/16/2018	10/30/2018	
Quarterly reporting - GenAd - 4th Q tr.	OM-Budget	10/16/2018	10/30/2018	
Quarterly reporting - BVA - 4th Q tr.	BVA	10/16/2018	10/30/2018	
Quarterly reporting - VBA GOE - 4th Q tr.	VBA	10/16/2018	10/30/2018	
Quarterly reporting - VBA - 4th Q tr.	VBA	10/16/2018	10/30/2018	
Quarterly reporting - NCA - 4th Q tr.	NCA	10/16/2018	10/30/2018	
Quarterly reporting - OIT - 4th Q tr.	OIT	10/16/2018	10/30/2018	
Quarterly reporting - Major Construction - 4th Q tr.	OALC/CFM	10/16/2018	10/30/2018	
Quarterly reporting - FTE - 4th Q tr.	OM-Budget	10/16/2018	10/30/2018	
Veterans Electronic Health Record - 4th Q tr.	EHR	10/16/2018	10/30/2018	
Caregivers	VHA	1/9/2019	1/23/2019	
Expenditure plan - Minor Construction	O AEM	3/8/2019	3/22/2019	
Medical staff retention	VHA	3/8/2019	3/22/2019	
Demand profile	VHA	3/9/2019	3/23/2019	

Upcoming VAOB Meetings

November 26 – Budget Execution and Performance Review

December 10 – Management Issues

December 24 – Cancelled

From: Darin Selnick <(b) (6) gmail.com>
To: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdl)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Fwd: DOT / FAA Placement Possibilities
Date: Fri Oct 19 2018 15:24:37 CDT
Attachments: (b) (6) SECNAV MIL BIO.doc
(b) (6) resume.doc
(b) (6) JPG
Secretary (b) (6) 2.jpg

Hi (b) (6)

Please call me when you have a chance on this.

Thanks

Darin

----- Forwarded message -----

From: (b) (6) <(b) (6) aol.com>
Date: Fri, Oct 19, 2018 at 12:05 PM
Subject: DOT / FAA Placement Possibilities
To: (b) (6) gmail.com>

Greetings Darin,

First, I'd like to thank you for your sound advice and liaison. It seems that quite a few people I've interacted with at DOT, FAA in particular, believe that my expertise and forward thought would be of great productive value in a number of programs there. While I'm flattered, there are several programs I'm easily capable of managing there. My strong military, commercial, civilian aviation, and Congressional consulting experience combined with my extensive program management experiences at Naval air Systems Command would fit nicely in FAA's Next Gen, ATO, or any other area they need management expertise in. As a results oriented, policy driven person, I am confident that we can do a lot to bring aviation management and procedures into the 21st century. UAV integration and air traffic management are areas we can improve, for sure.

I'm asking if you would use your contacts to float my resume over at DOT / FAA for serious consideration as I'm readily available immediately. If I'm going to continued to be asked to consult with some of the FAA employees, I should be on the payroll (smile). I can ensure that I'll do whatever is necessary too get the President's agenda up and running at that organization with tangible metrics, and goal-oriented results.

Please find attached my resume, military bio, and a couple of pictures, though the Navy photo is now dated.

Again, thank you for any assistance you're able to provide. My hope the WH PPO will be agreeable.

(b) (6)
(703) 732- (b) (6) cell / text

Owner: Darin Selnick <(b) (6) gmail.com>
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Last Modified: Fri Oct 19 14:24:37 CDT 2018

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CAREER HIGHLIGHTS, UNITED STATES NAVY (continued):

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Excellent personal and professional references upon request.

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Cc:
Bcc:
Subject: VSO Communicators Meeting
Date: Fri Oct 12 2018 14:37:54 CDT

Attachments:

StartTime: Wed Nov 07 09:45:00 Central Standard Time 2018

EndTime: Wed Nov 07 11:15:00 Central Standard Time 2018

Location: 810 Vermont Avenue, Room 910

Invitees: (b) (6) moaa.org); (b) (6) purpleheart.org); (b) (6), (b) (2) amvets.org); (b) (6) hqafsa.org); (b) (6) mowww.org); (b) (6), (b) (2) davmail.org); (b) (6), (b) (2) woundedwarriorproject.org); (b) (6) studentveterans.org); (b) (6) legion.org); (b) (6) bva.org); (b) (6) co. waseca.mn.us); (b) (6) fra.org); Dan Caldwell (dcaldwell@cv4a.org); (b) (6) (VFW); (b) (6), (b) (2) treadc.org); (b) (6) moaa.org); (b) (6) (DISABLED ACCT); (b) (6), (b) (2) va.gov); (b) (6), (b) (2) jwv.org); Hutton, James; (b) (6) coausphs.org); (b) (6) va.gov); (b) (6) verizon.net); (b) (6) - The American Legion (b) (6) woundedwarriorproject.org); (b) (6) amvets.org); (b) (6), (b) (2) - Department of Veterans Affairs (b) (6) va.gov); (b) (6) usmcra.org); (b) (6) nacvso.org); (b) (6) hqafsa.org); (b) (6) hqafsa.org); (b) (6) VBAVACO; (b) (6) redcross.org); (b) (6) mcleague.org); (b) (6) legion.org); (b) (6) studentveterans.org); (b) (6) davmail.org); (b) (6) woundedwarriorproject.org); (b) (6), (b) (2) bva.org); (b) (6), (b) (2) iava.org); (b) (6) maine.gov); (b) (6) hqafsa.org); (b) (6) amvets.org); (b) (6) vva.org); (b) (6), (b) (2) R. VBAVACO (b) (6), (b) (2) va.gov); (b) (6) teamrubiconusa.org); (b) (6) vfw.org); (b) (6) vfw.org); (b) (6) teamrwb.org); (b) (6) Michelle B; (b) (6) VBAVACO; Syrek, Christopher D. (Chris); (b) (6) dav.org); (b) (6) iava.org); (b) (6) moaa.org); (b) (6) pva.org); (b) (6) Wagner, John (Wolf); (b) (6)

Recurring: No

ShowReminder: No

Accepted: No

This invitation is for the VSO Communicators Meeting at the VA Central Office. I know that November is a very busy month for everyone. Please let me know whether you or someone from your organization will be able to attend.

This meeting will take place at 810 Vermont Avenue, NW, in the Office of Public and Intergovernmental Affairs', glass conference room 910. Someone will meet you in the lobby and escort you up after you have gone through security. An agenda will follow under separate cover.

Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

Explore VA today! <http://explore.va.gov/>

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Cc:
Bcc:
Subject: VSO Communicators Meeting
Date: Fri Oct 12 2018 14:37:52 CDT
Attachments:

This invitation is for the VSO Communicators Meeting at the VA Central Office. I know that November is a very busy month for everyone. Please let me know whether you or someone from your organization will be able to attend.

This meeting will take place at 810 Vermont Avenue, NW, in the Office of Public and Intergovernmental Affairs', glass conference room 910. Someone will meet you in the lobby and escort you up after you have gone through security. An agenda will follow under separate cover.

Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

Explore VA today! <http://explore.va.gov/>

From: Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: RLW </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: RE: CVA Letter to SECVA on HR 299 Blue Water Navy
Date: Wed Sep 19 2018 21:22:00 CDT
Attachments:

I did mention to OPIA that an op-ed is worth discussing.

Getting impression the (b) (5) .

Sent with Good (www.good.com)

From: RLW
Sent: Wednesday, September 19, 2018 6:01:50 PM
To: Tucker, Brooks
Cc: Powers, Pamela
Subject: RE: CVA Letter to SECVA on HR 299 Blue Water Navy

Certainly (b) (5) (b) (5)

Sent with Good (www.good.com)

From: Tucker, Brooks
Sent: Wednesday, September 19, 2018 5:52:49 PM
To: RLW
Cc: (b) (6) Powers, Pamela; (b) (6) Byrne, Jim; Lawrence, Paul R., VBAVACO
Subject: CVA Letter to SECVA on HR 299 Blue Water Navy

Mr Secretary, Please see attached, which was received this evening by OCLA.

Brooks

From: Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
To: RLW </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Cc: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Bcc:
Subject: RE: CVA Letter to SECVA on HR 299 Blue Water Navy
Date: Wed Sep 19 2018 21:20:04 CDT
Attachments:

Yes, when they said a letter was coming I was under impression they would [REDACTED] (b) (5)

Sent with Good (www.good.com)

From: RLW
Sent: Wednesday, September 19, 2018 6:01:50 PM
To: Tucker, Brooks
Cc: Powers, Pamela
Subject: RE: CVA Letter to SECVA on HR 299 Blue Water Navy

Certainly [REDACTED] (b) (5)

Sent with Good (www.good.com)

From: Tucker, Brooks
Sent: Wednesday, September 19, 2018 5:52:49 PM
To: RLW
Cc: [REDACTED] (b) (6) Powers, Pamela; [REDACTED] (b) (6) Byrne, Jim; Lawrence, Paul R., VBAVACO
Subject: CVA Letter to SECVA on HR 299 Blue Water Navy

Mr Secretary, Please see attached, which was received this evening by OCLA.

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From: RLW </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
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Cc: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Bcc: [REDACTED]
Subject: RE: CVA Letter to SECVA on HR 299 Blue Water Navy
Date: Wed Sep 19 2018 21:01:50 CDT
Attachments:

Certainly [REDACTED] (b) (6)

Sent with Good (www.good.com)

From: Tucker, Brooks
Sent: Wednesday, September 19, 2018 5:52:49 PM
To: RLW
Cc: [REDACTED] (b) (6) Powers, Pamela; [REDACTED] (b) (6) Byrne, Jim; Lawrence, Paul R., VBAVACO
Subject: CVA Letter to SECVA on HR 299 Blue Water Navy

Mr Secretary, Please see attached, which was received this evening by OCLA.

Brooks

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Bcc:
Subject: CVA Letter to SECVA on HR 299 Blue Water Navy
Date: Wed Sep 19 2018 20:52:49 CDT
Attachments: CVA_Letter of Opposition_Blue Water Navy Vietnam Vets Act.pdf

Mr Secretary, Please see attached, which was received this evening by OCLA.

Brooks

Sent with Good (www.good.com)

Owner: Tucker, Brooks </o=va/ou=exchange administrative group (fydibohf23spdlt)
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Filename: CVA_Letter of Opposition_Blue Water Navy Vietnam Vets Act.pdf
Last Modified: Wed Sep 19 19:52:49 CDT 2018



CONCERNED
VETERANS
FOR AMERICA

September 12, 2018

Secretary Robert Wilkie
Department of Veterans Affairs
810 Vermont Avenue, NW.
Washington, D.C. 20420

Dear Secretary Wilkie,

On behalf of Concerned Veterans for America, I would like to express our support for your position opposing H.R. 299, the Blue Water Navy Vietnam Veterans Act of 2018. While we recognize the good intentions of those in Congress who want to ensure veterans receive the benefits they were promised, we agree with the Department of Veterans Affairs (VA) that this sets an alarming precedent by creating a new presumption without the support of scientific evidence.

With the Institute of Medicine concluding in 2011 that exposure to Agent Orange among Blue Water Navy Veterans “cannot reasonably be determined,” lawmakers should end efforts to expand benefits until research conclusively supports such a change. This process protects the integrity of the VA’s benefits system and ensures the claims of veterans with clear service-connected injuries are prioritized and processed in a timely manner. The VA already applies a generous presumption of exposure to Agent Orange for Vietnam Veterans who served on brown water vessels or on ships that entered inland waterways. Expanding benefits without the backing of scientific evidence is a disservice to future and current generations of veterans.

The VA has long struggled to process current claims and appeals in a timely manner. This bill would add an influx of complicated and nuanced claims to an overburdened system. Due to the lack of conclusive scientific evidence to support this policy change, the bill includes a demarcation line for eligibility that might be impossible for the VA to even utilize. This combination of factors will further strain the VA benefits system.

Additionally, any expansion of benefits, particularly retroactive benefits, carries a significant price tag. The VA’s net cost estimate of \$5.5 billion over 10 years is likely conservative at best and the pay-for included in the bill is insufficient to cover the additional costs.

Accordingly, we urge the VA to continue to oppose the Blue Water Navy Veterans Act.

Sincerely,

Dan Caldwell
Executive Director
Concerned Veterans for America

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Bcc:

Subject: VSO Communicators Meeting
Date: Fri Sep 07 2018 13:52:00 CDT
Attachments:

When: Wednesday, September 12, 2018 11:00 AM-12:30 PM. (UTC-05:00) Eastern Time (US & Canada)

~~*~*~*~*~*~*~*

This invitation is for the VSO Communicators Meeting at the VA Central Office. The meeting will take place at 810 Vermont Avenue, NW, in the Office of Public and Intergovernmental Affairs', glass conference room 910. Someone will meet you in the lobby and escort you up after you have gone through security.

Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

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Subject: VSO Communicators Meeting
Date: Fri Sep 07 2018 13:52:00 CDT
Attachments:

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Cc:
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Subject: SECVA VSO Interactions
Date: Wed Sep 05 2018 18:31:25 CDT
Attachments: SECVA VSO Attendance.docx

Pam,

See below/attached for SECVA VSO interactions you asked for. If he doesn't want to include the 1 v. 1 meetings or the breakfast that is fine, at least wanted to provide the info. VHA visits you asked for are forthcoming, will have by tomorrow.

EVENT

DATE

VSO Breakfast

4/6/2018

VSO Breakfast

8/21/2018

1:1 American Legion

5/16/2018

1:1 VFW

5/4/2018

1:1 AMVETS

5/3/2018

1:1 DAV

5/1/2018

1:1 PVA

5/8/2018

1:1 V V A

5/18/2018

1:1 WWP

4/23/2018

1:1 CVA

5/4/2018

1:1 BVA

4/4/2018

AMVETS National Convention

8/8/2018 Orlando, FL

American Legion National Convention

8/29/2018 Minneapolis, MN

Paralyzed Veterans of America National Convention

8/30/2018 Dallas, TX

Jewish War Veterans Convention

8/10/2018 Tampa, FL

White House VSO Group Meeting

5/16/2018

Owner: Syrek, Christopher D. (Chris) </o=va/ou=exchange administrative group
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Filename: SECVA VSO Attendance.docx
Last Modified: Wed Sep 05 17:31:25 CDT 2018

SECVA VSO Attendance

EVENT	DATE
VSO Breakfast	4/6/2018
VSO Breakfast	8/21/2018
1:1 American Legion	5/16/2018
1:1 VFW	5/4/2018
1:1 AMVETS	5/3/2018
1:1 DAV	5/1/2018
1:1 PVA	5/8/2018
1:1 V V A	5/18/2018
1:1 WWP	4/23/2018
1:1 CVA	5/4/2018
1:1 BVA	4/4/2018
AMVETS National Convention	8/8/2018 Orlando, FL
American Legion National Convention	8/29/2018 Minneapolis, MN
Paralyzed Veterans of America National Convention	8/30/2018 Dallas, TX
Jewish War Veterans Convention	8/10/2018 Tampa, FL
White House VSO Group Meeting	5/16/2018

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VSO Communicators Meeting

Tue Sep 04 2018 10:16:52 CDT

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Attachments:

VSO Communicators Meeting

Tue Sep 04 2018 10:16:52 CDT

This invitation is for the VSO Communicators Meeting at the VA Central Office. The meeting will take place at 810 Vermont Avenue, NW, in the Office of Public and Intergovernmental Affairs', glass conference room 910. Someone will meet you in the lobby and escort you up after you have gone through security.

Several representatives that I have spoken to preferred to meet a little later in the day than our previous time of 8AM. Please let me know if you can attend at this new time. If this time works for the majority of you I will keep it, if not we can reschedule.

Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

Explore VA today! <http://explore.va.gov/>

From: (b) (6) </o=va/ou=vha office of
information/cn=recipients/cn=(b) (6)>
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Bcc:
Subject: VSO Communicators Meeting
Date: Tue Sep 04 2018 10:16:52 CDT
Attachments:

This invitation is for the VSO Communicators Meeting at the VA Central Office. The meeting will take place at 810 Vermont Avenue, NW, in the Office of Public and Intergovernmental Affairs', glass conference room 910. Someone will meet you in the lobby and escort you up after you have gone through security.

Several representatives that I have spoken to preferred to meet a little later in the day than our previous time of 8AM. Please let me know if you can attend at this new time. If this time works for the majority of you I will keep it, if not we can reschedule.

Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

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Bcc:

Subject: VSO Communicators Meeting
Date: Fri Aug 24 2018 13:13:54 CDT
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Bcc:

Subject: VSO Communicators Meeting

Date: Fri Aug 24 2018 13:13:54 CDT

Attachments:

When: Wednesday, September 12, 2018 11:00 AM-12:30 PM. (UTC-05:00) Eastern Time (US & Canada)

Where: 810 Vermont Ave, OPIA Glass Conference Room

~~*~*~*~*~*~*~*~*

This invitation is for the VSO Communicators Meeting at the VA Central Office. The meeting will take place at 810 Vermont Avenue, NW, in the Office of Public and Intergovernmental Affairs', glass conference room 910. Someone will meet you in the lobby and escort you up after you have gone

through security.

Several representatives that I have spoken to preferred to meet a little later in the day than our previous time of 8AM. Please let me know if you can attend at this new time. If this time works for the majority of you I will keep it, if not we can reschedule.

Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

Explore VA today! <http://explore.va.gov/>

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information/cn=recipients/cn=(b) (6)>
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Bcc:
Subject: VSO Communicators Meeting
Date: Fri Aug 24 2018 13:13:54 CDT
Attachments:

When: Wednesday, September 12, 2018 11:00 AM-12:30 PM. (UTC-05:00) Eastern Time (US & Canada)
Where: 810 Vermont Ave, OPIA Glass Conference Room

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This invitation is for the VSO Communicators Meeting at the VA Central Office. The meeting will take place at 810 Vermont Avenue, NW, in the Office of Public and Intergovernmental Affairs', glass conference room 910. Someone will meet you in the lobby and escort you up after you have gone

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Best,

(b) (6)

Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

Phone: 202.461. (b) (6)

Cell: 202.746. (b) (6)

E-mail: (b) (6) va.gov

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Cc:

Bcc:

Subject: VSO Communicators Meeting
Date: Fri Aug 24 2018 12:59:49 CDT
Attachments:

When: Wednesday, September 12, 2018 11:00 AM-12:30 PM. (UTC-05:00) Eastern Time (US & Canada)
Where: 810 Vermont Ave, OPIA Glass Conference Room

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Public Affairs Specialist

National Veterans Outreach Office

Department of Veterans Affairs

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E-mail: (b) (6) va.gov

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Policy Team <policy@iava.org>
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(b) (6) <(b) (6) legion.org>; (b) (6)
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<(b) (6) woundedwarriorproject.org>; (b) (6)
<(b) (6) moaa.org>; (b) (6) <(b) (6) vfw.org>; IAVA
Policy Team <policy@iava.org>

Cc:

(b) (6) </o=va/ou=exchange
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(b) (6) <(b) (6) stclaircounty.org>; (b) (6)
(b) (6) </o=va/ou=infrastructure/cn=recipients/cn=(b) (6)

Bcc:

Subject: VSO Communicators Meeting
Date: Fri Aug 24 2018 12:59:49 CDT
Attachments:

From: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
To: RLW </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Cc: Syrek, Christopher D. (Chris) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Bcc:
Subject: HR Numbers & VEO Breakfast
Date: Mon Aug 20 2018 17:39:41 CDT
Attachments: VSO Breakfast Agenda.docx

Sir,

I know Chris talked to you about the HR Release and you had asked for the draft. I just looked at it and it is a [REDACTED] (b) (5)

Also, attached is the invite list and suggested agenda. We will make sure this is done sooner and a good product is provided in the future.

Respectfully,

Pam

Pamela Powers

Veterans Affairs Chief of Staff

Office: 202-461-4846

Cell: 202-430-0049

Pamela.powers@VA.gov

Owner: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=[REDACTED]
Filename: VSO Breakfast Agenda.docx
Last Modified: Mon Aug 20 16:39:41 CDT 2018

VSO Breakfast Tuesday, August 21, 2018 8:00 to 9:00 am	
VA Invitees	<p>The Honorable Robert Wilkie, Secretary Pamela Powers, Chief of Staff, Office of the Secretary Dr. Paul Lawrence, Under Secretary, Veterans Benefits Administration, VA Randy Reeves, Under Secretary, National Cemetery Administration, VA Jim Byrne, Office of General Counsel, VA Brooks Tucker, Assistant Secretary, OCLA Dr. Steve Lieberman, Acting, Principal Deputy Under Secretary for Health, VHA</p>
VSO Invitees	<p>(b) (6) Executive Director, The American Legion (TAL) (b) (6) Executive Director, Disabled American Veterans (DAV) (b) (6) Executive Director, Paralyzed Veterans of America (PVA) (b) (6) Executive Director, American Veterans (AMVETS) (b) (6) Deputy Director for Policy & Government Affairs, Vietnam Veterans of America (VVA) (b) (6) Senior Director, Government Relations for Veterans-Wounded Warrior Care Military Officers Association of America (MOAA) (b) (6) Senior Vice President, Government and Community Relations, Wounded Warrior Project (WWP) (b) (6) President and CEO, Student Veterans of America (SVA) (b) (6) Deputy Director, Concerned Veterans of America (CVA) (b) (6) (alt (b) (6)) Washington, D.C. Director (Chief Advocacy), Independence Fund (b) (6) Executive Director, AMVETS (b) (6) National Executive Director, Fleet Reserve Association (b) (6) Executive Director, Veterans of Foreign Wars (b) (6), (b) (2) Director of Public Affairs, Blinded Veterans Association (b) (6) (assistant to (b) (6), (b) (2)) Blinded Veterans Association</p>
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Secretary's Priorities	Customer Service Bottom-up Organization Business transformation
Electronic Health Records Management Update	Cerner Kickoff Solicit VSO input/debrief from Cerner Kickoff Event I and my team are confident that this is the right Solution
Blue Water Navy	VA's view is that the evidence-based approach to creating or expanding presumptions should be maintained. Presumptions of exposure and/or medical causation should always be supported by historical, scientific, and/or medical evidence about the specific population of Veterans affected. VA recognizes Congress's prerogative in creating or expanding presumptions. However, VA is concerned that new Congressionally-created presumptions that are not adequately supported by evidence will erode confidence in the soundness and fairness of the Veterans' benefits system. Such statutory presumptions will lead to increased pressure on VA to create or expand additional presumptions administratively, under a similarly liberal approach.

From: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
To: RLW </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Cc: Syrek, Christopher D. (Chris) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=[REDACTED] (b) (6)>
Bcc:
Subject: HR Numbers & VEO Breakfast
Date: Mon Aug 20 2018 17:39:41 CDT
Attachments: VSO Breakfast Agenda.docx

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Veterans Affairs Chief of Staff

Office: 202-461-4846

Cell: 202-430-0049

Pamela.powers@VA.gov

Owner: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)
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To: Powers, Pamela </o=va/ou=exchange
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Cc:
Bcc:
Subject: Draft agenda for VSO breakfast
Date: Mon Aug 20 2018 17:33:49 CDT
Attachments: Document5.docx

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
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From: (b) (6) </o=va/ou=exchange
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To: Powers, Pamela </o=va/ou=exchange
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(Chris) </o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: Revised Seating Chart
Date: Mon Aug 20 2018 16:52:48 CDT
Attachments: SECVA VSO Bkfst Aug 21 Seating Chart.docx

In order to accommodate the larger group at the table and keep the Secretary in the middle we've adjusted the chart accordingly.

Please see attached.

*Note: Changes can be made up to the start of the breakfast.

Send me!

(b) (6)

Senior Advisor, VSO Liaison Office of the Secretary

Department of Veteran Affairs

810 Vermont Avenue, NW

Washington, D.C. 20420

Desk: (202) 461-(b) (6)

Email: (b) (6)@va.gov

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
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Filename: SECVA VSO Bkfst Aug 21 Seating Chart.docx
Last Modified: Mon Aug 20 15:52:48 CDT 2018

SECVA VSO Breakfast
Tuesday, Aug 21. 2018
8:00-9:00am
OBCR

Seating Chart

(b) (6)	FRA	
(b) (6)	AMVETS	(b) (6)
Jim Byrnes OGC		(b) (6)
Brooks Tucker Assistant Secretary, OCLA		(b) (6)
(b) (6), (b) (2)	VSO Liaison	(b) (6)
Pamela Powers Chief of Staff		(b) (6)
Secretary Wilkie		(b) (6)
(b) (6), (b) (7)(C)	Special Assistant to the President and Deputy Director for the White House Public Liaison	(b) (6) (ALTERNATE) (b) (6)
		(b) (6)
Randy Reeves US For Memorial Affairs		(b) (6)
Paul Lawrence US VBA		(b) (6)
Dr. Steven Lieberman P/DUSH		(b) (6)
(b) (5)	PVA	(b) (6) (Assistant to) (b) (6)
(b) (6)	Gold Star Wives	(b) (6)
		(b) (6)



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Cc: Syrek, Christopher D. (Chris) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Bcc:
Subject: Agenda Topics
Date: Mon Aug 20 2018 16:37:33 CDT
Attachments: SECVA VSO Bkfst Aug 21 Seating Chart.docx
VSO Breakfast Invitees and Agenda Aug21 2018.docx

Apologies, I sent out the wrong agenda for tomorrow's VSO breakfast in my previous email.

Please find the updated agenda and seating chart attached.

Send me!

(b) (6)

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6)
Filename: SECVA VSO Bkfst Aug 21 Seating Chart.docx
Last Modified: Mon Aug 20 15:37:33 CDT 2018

SECVA VSO Breakfast
Tuesday, Aug 21, 2018
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Secretary Wilkie		(b) (6)	The American Legion
Pamela Powers	Chief of Staff	(b) (6)	Concerned Veterans of America
(b) (6), (b) (7)(C)	Special Assistant to the President and Deputy Director for the White House Public Liaison	(b) (6) (ALTERNATE) (b) (6)	Independence Fund
(b) (6), (b) (2)	VSO Liaison	(b) (6)	DAV
Randy Reeves	US For Memorial Affairs	(b) (6)	SVA
Paul Lawrence	US VBA	(b) (6)	VVA
Dr. Steven Lieberman	P/DUSH	(b) (6) (Assistant to) (b) (6)	Blinded Veterans Association
(b) (5)	PVA		
(b) (6)	Gold Star Wives	(b) (6)	Blinded Veterans Association



Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6)
Filename: VSO Breakfast Invitees and Agenda Aug21 2018.docx
Last Modified: Mon Aug 20 15:37:33 CDT 2018

Event/Meeting: VSO Breakfast with The Honorable Robert Wilkie, Acting Secretary, Department of Veterans Affairs

Date/Time: Tuesday, August 21st – 8:00 – 9:00 AM

Location: VACO Omar Bradley Conference Room (OBCR)

VA Invitees:

The Honorable Robert Wilkie, Acting Secretary
Pamela Powers, Chief of Staff, Office of the Secretary
Dr. Paul Lawrence, Under Secretary, Veterans Benefits Administration, VA
Randy Reeves, Under Secretary, National Cemetery Administration, VA
Jim Byrne, Office of General Counsel, VA

VSO Invitees:

(b) (6) Executive Director, The American Legion (TAL)
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(b) (6) Executive Director, Veterans of Foreign Wars
(b) (6), Director of Public Affairs, Blinded Veterans Association
(b) (6) (assistant to (b) (6) Blinded Veterans Association

Agenda Topics:

Welcome/Introductions – The Honorable Robert Wilkie, Acting Secretary

Update – Leadership Updates

- Pamela Powers
- Col (b) (6), (b) (7)(C)
- Kevin Krhon
- Peter O'Rourke
- Jacquelyn Hayes-Byrd
- Dr. Richard A. Stone – Dr. Stone was appointed Executive in Charge, Office of the Under Secretary for Health, effective July 18, 2018. An Army Veteran, previously served as PDUSH from 2016 to 2017
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- Dr. Steven Lieberman –Promoted from Assistant Deputy Under Secretary for Access for Care to PDUSH. Dr. Lieberman has over 25 years' experience with VHA

Priorities

- Customer Service
- Bottom-up Organization
- Business transformation

EHRM Update

- Cerner Kickoff
- Solicit VSO input/debrief from Cerner Kickoff Event
- I and my team are confident that this is the right Solution

Blue Water Navy

- VA's view is that the evidence-based approach to creating or expanding presumptions should be maintained.
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NEWS Announcements

Clarify collective bargaining authority

**VA Secretary underscores low unemployment
for Veterans under President Trump**

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6) </o=va/ou=va martinsburg/cn=recipients/cn=(b) (6) (b) (6)> </o=va/ou=va martinsburg/cn=recipients/cn=vacomitchm1>; Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: RE: Thursday
Date: Mon Aug 20 2018 16:25:29 CDT
Attachments: SECVA VSO Bkfst Aug 21 Seating Chart.docx

Got it thank you!

See attached seating chart for tomorrow morning's breakfast.

Thank you.

(b) (6)

From: (b) (6)
Sent: Monday, August 20, 2018 4:21 PM
To: (b) (6) <(b) (6) va.gov>
Subject: Thursday

Hi (b) (6) – need to move your meeting on Thursday to 2pm. Thank you.

(b) (6)

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6)
Filename: SECVA VSO Bkfst Aug 21 Seating Chart.docx
Last Modified: Mon Aug 20 15:25:29 CDT 2018

**SECVA VSO Breakfast
Tuesday, Aug 21, 2018
8:00-9:00am
OBCR**

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Secretary Wilkie		(b) (6)	The American Legion
Pamela Powers Chief of Staff		(b) (6)	Concerned Veterans of America
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(b) (6), (b) (2) VSO Liaison		(b) (6)	DAV
Randy Reeves US For Memorial Affairs		(b) (5)	SVA
Paul Lawrence US VBA		(b) (5)	VVA
Dr. Steven Lieberman P/DUSH		(b) (6) (Assistant to (b) (6), (b) (2)	
(b) (5) PVA			Blinded Veterans Association
(b) (6) Gold Star Wives		(b) (6), (b) (2)	Blinded Veterans Association



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From: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6)@outlook.com
<(b) (6)@outlook.com>
Cc:
Bcc:
Subject: FW: [EXTERNAL] VA Reform Agenda – Five Ways to Move Forward
Date: Sun Aug 19 2018 20:59:03 CDT
Attachments: Commission on Care_Final Report_063016_1815-3.pdf
Commission-on-Care-SECVA-to-POTUS-memo-and-enclosure-tech-edit-page-4....pdf
MISSION Act 2018_6_22 Deadlines and Milestones spreadsheet.xlsx
VA Directives Draft 060518.docx
VA Governance Directive0214.pdf
VA Reform Agenda 10082018.docx
VA Reform and Modernization Commission.docx
VA-ETP-FINAL-JULY-2003.pdf

Sent with Good (www.good.com)

From: Darin Selnick
Sent: Wednesday, August 15, 2018 10:08:20 PM
To: Powers, Pamela
Cc: (b) (6), (b) (7)(C), (b) (6)
Subject: [EXTERNAL] VA Reform Agenda – Five Ways to Move Forward

Hi Pam

Last week SECVA Wilkie asked me to put together for him, my ideas on 5 Ways to get VA reform moving.

Attached - VA Reform Agenda, are those 5 ideas. The additional attachments support the document and are referenced.

Can you please ensure that this gets to SECVA. I am happy to discuss them with you when I see you on Monday. Also let me know if SECVA would like to discuss this when I am in DC next week or on the phone sometime.

Best Regards

Darin Selnick
571-234-6003

Owner: Powers, Pamela </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=[REDACTED]
Filename: Commission on Care_Final Report_063016_1815-3.pdf
Last Modified: Sun Aug 19 19:59:03 CDT 2018

Commission on Care

Final Report



COMMISSION ON CARE

June 30, 2016

COMMISSION ON CARE

Final Report of the Commission on Care

June 30, 2016

Commission on Care
1575 I Street, NW
Washington, DC 20005



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COMMISSION ON CARE

1575 I Street, NW ▪ Washington, DC 20005

June 30, 2016

We are honored to submit to the President, through the Secretary of Veterans Affairs, in accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for transforming veterans' health care. We believe these recommendations are essential to ensure that our nation's veterans receive the health care they need and deserve, both now and in the future.

We worked with an absolute commitment to putting veterans at the heart of our deliberations, and believe our recommendations will create an integrated, community-based health care system for veterans that will be sustainable for the long term. During the term of the Commission on Care, we evaluated the 4,000-page *Independent Assessment Report*; held public meetings; listened to a broad range of stakeholders, including veterans and leaders of veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; and exchanged ideas with individual veterans, VA and VHA leaders, VHA employees and health care providers, members of Congress, economists, and health care experts.

Overall, the Commissioners agree with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. This evidence shows that although care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. The Commissioners also agree that America's veterans deserve much better, that many profound deficiencies in VHA operations require urgent reform, and that America's veterans deserve a better organized, high-performing health care system.

The most public and glaring deficiency was access problems. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary program allowing for greater choice. The Commission finds, however, that the design and execution of the *Choice Program* are flawed. In its place, we offer specific recommendations for standing up integrated veteran-centric, community-based delivery networks that will optimize the balance of access, quality, and cost-effectiveness.

The Commission also finds that the long-term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires fundamental changes in governance and leadership of VHA to guide the organization during the next two decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care system.

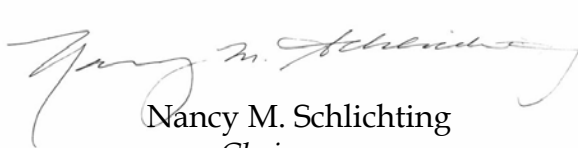
VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement. VHA has begun to make some of the most urgently needed changes outlined in the *Independent Assessment Report*, and we support this important work.

Implementing the recommendations in this report will greatly enhance VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Foundational among these changes is forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.

The remaining recommendations work in harmony to ensure veterans receive timely access to care, have options for where and how they receive care, are cared for in an environment that embraces diversity and inclusion, and are supported in making informed decisions about their own health and well-being. These recommendations are

not small-scale fixes to finite problems. Instead, they constitute a bold transformation of a complex system that will take years to fully realize, but that our country must undertake to provide our veterans with the high-quality health care they richly deserve.

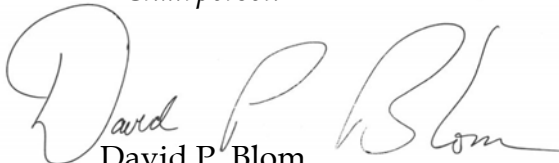
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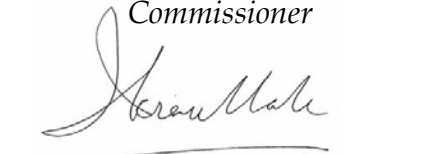
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EXECUTIVE SUMMARY

Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.¹ The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

¹ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

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- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

Mission

Provide eligible veterans prompt access to quality health care.

Values

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; *Governance, Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model*, *Leadership Implementation*, *History as a Context for Systemic Transformation*, *Veteran Feedback*, and *Additional Resources*. These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

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- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.²

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.³ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁴

² RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

³ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁴ Ibid., 95.

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VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

The Commission Recommends That. . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁵ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁷ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁸

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

⁵ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁸ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁹

VHA has a program of system engineering — Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, Assessment F (Workflow—Clinical), 14 and A-2, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.¹⁰ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.¹¹

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

¹⁰ Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*, U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, <http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf>.

¹¹ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹² VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

¹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.¹³

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.¹⁴ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.¹⁵ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”¹⁶ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,¹⁷ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands”¹⁸ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

¹⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

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Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

To achieve the Commission’s vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set—identical to private-sector standards—will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders’ performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.

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- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.¹⁹

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

¹⁹ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

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INTRODUCTION

Two years ago, a scandal over VHA employees manipulating data systems to cover up long delays in scheduling care left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. In response, the White House appointed new leadership, including the secretary of veterans affairs (SECVA) and undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The Commission on Care's work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

The charge given this Commission, with its emphasis on access to care, reflects the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the Commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, however, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement, and in where and how care is delivered. VHA must keep pace with, and even be a leader, in these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand *access* to reflect not only timeliness, but care quality and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone; Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report*

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emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term *transformation*, the commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the obligation owed those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

Others may question how a system with the range of problems VHA faces can meaningfully improve, let alone realize a transformation. Mindful of its 20-year charge, the Commission notes that VA health care faced similar challenges 20 years ago and underwent a historic transformation. The long history of the VA health care system has seen highs and lows. Among the lessons in that history is that the mission—to care for those who have borne the battle—is not only powerful, but enduring. History has demonstrated that transformation can be achieved, but also that structures and strategies for sustainability must be built into the framework.

As the commission report emphasizes, transformation is difficult. It is a process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. VHA has begun some of this work; our recommendations in some areas acknowledge VHA's efforts and suggest that where they are aligned with the Commission's recommendations, they should be sustained. The fruits of the transformation, though, will not be realized over the course of a single Congress or a single 4-year administration. For this reason, the Commission, strongly recommends a new form of governance and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission recommends, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION RECOMMENDATIONS

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Problem

Due to changing veteran demographics, increasing demand for VHA care in some markets, and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was intended to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

The Commission Recommends That . . .

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Integrated, community-based health care networks be developed with *local* VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.

Recommendations continue on next page. =>

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Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

Background

VHA has long had authority to purchase hospital care and medical services based on geographic inaccessibility or VHA's lack of a required service.²⁰ In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under the Patient-Centered Community Care (PC3) Program.²¹ In all cases, purchased care was a secondary means of providing care, to be used "when VA health care facilities are not feasibly available."²² Even before the creation of the *Choice Program* in 2014, some 10 percent of VHA medical spending went for purchased-care services.

When Congress enabled what became known as the *Choice Program*, it tasked VHA with implementing a fundamentally new mechanism for purchasing care. Unlike traditional purchased-care authority (which still exists), the *Choice Program* promises veterans who meet specific geographic or wait-time-related criteria that they can elect to receive treatment from within a network of a community providers.²³

Under the current *Choice Program*, however, most VHA patients are promised little or no actual choice of providers outside VHA. To be eligible for the program, VHA patients must meet the following criteria:²⁴

The Commission Recommends That . . .

<= Recommendations continued from previous page.

- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- The VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

²⁰ Contracts for Hospital Care and Medical Services in Non-Department Facilities, 38 U.S.C. § 1703(a).

²¹ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 37, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

²² Non-VA Medical Care Program, VHA Directive 1601, (2013).

²³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014).

²⁴ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014), as amended by Construction Authorization and Choice Improvement Act, Pub. L. No. 114-19, 129 Stat. 215, (2015). The Independent Assessment proposed that VA should "Develop and implement more sensitive standards of geographic access to care. VA should compare the 'one-size-fits-all' approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This

- Live more than 40 miles from the closest VHA facility with a full-time primary care provider
- Cannot be seen within 30 days of the date veterans' providers indicate they need to be seen.
- Cannot be seen within 30 days of veterans' preferred appointment date if providers have not provided a specific appointment date.

This standard is difficult to reconcile with other statutory priorities for VA care.²⁵ For example, under the *Choice Program*, a veteran with severe service-incurred health conditions may have no access to providers outside VHA, yet a veteran with no service-related disabilities does have such a choice.²⁶ Implementing the *Choice Program* has posed challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers²⁷ have been confused because of conflicting requirements and processes in eligibility rules, referrals and authorizations, provider credentialing and network development, care coordination, and claims management.²⁸

Adding to the confusion is the fact that VHA, facing a 90-day deadline for implementing the program, outsourced the creation and management of its provider networks to two private contractors, thus blurring lines of responsibility and leaving both patients and providers confused about who exactly holds responsibility for what. In execution, the program has aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.²⁹

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.³⁰ VA's report also set out a plan for establishing high-performing networks. The report acknowledged that "[n]o organization can excel at every capability," and that "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."³¹ As further articulated by Dr. David Shulkin, USH:

assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care."

²⁵ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705.

²⁶ Ibid.

²⁷ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 43, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf. Pete Henry, retired VA medical center director, response to questions about the challenges facing field officials, email to Commission on Care staff, January 18, 2016.

²⁸ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

²⁹ "Despite \$10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," Quil Lawrence, Eric Whitney, and Michael Tomsic, accessed May 16, 2016, <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>.

³⁰ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

³¹ Ibid., 18.

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It's become apparent that the VA alone cannot meet all the health care needs of U.S. veterans. The VA's mission and scope are not comparable to those of other U.S. health systems. Few other systems enroll patients in areas where they have no facilities for delivering care. Fewer still provide comprehensive medical, behavioral, and social services to a defined population of patients, establishing lifelong relationships with them. These realities, combined with the wait-time crisis, have led the VA to reexamine its approach to care delivery . . . [A]ddressing veterans' needs requires a new model of care: rather than remaining primarily a direct care provider, the VA should become an integrated payer and provider. This new vision would compel the VA to strengthen its current components that are uniquely positioned to meet veterans' needs, while working with the private sector to address critical access issues.³²

Analysis

VHA needs systemic transformation, and merely clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, is not sufficient to achieve that goal. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with the new VHA Care System, available to all enrolled veterans.

The VHA Care System is defined as VHA employed providers and facilities; Department of Defense (DoD) and other federally-funded providers and facilities; and community-based, VHA-credentialed community providers and facilities, forming integrated networks to deliver high-quality and high-access care to enrolled veterans across the United States. VHA may establish the networks with the use of national contractors or with internal resources, but networks should be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.

This new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or greater scope than is available in the private sector, either locally or nationally³³ They include specialized behavioral health care programs, integrated behavioral health and primary care (in patient-aligned care teams), specialized rehabilitation services, spinal cord injury centers, and services for homeless veterans.³⁴ These and similar programs and services are core competencies and special capabilities that serve the needs of combat veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.³⁵ Because of its unique capabilities and competencies, VHA should play an important role in expanding and enhancing the care of veterans across the United States by collaborating with local network providers to improve the

³² David J. Shulkin, "Beyond the VA Crisis — Becoming a High-Performance Network," *New England Journal of Medicine*, 374, (2016): 1003-1005, accessed June 15, 2016, <http://doi.org/10.1056/NEJMp1600307>.

³³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

³⁴ Special capabilities like spinal cord injury care, which draw from specialty care available in the full-service hospitals in which they are currently provided, merit continued support and investment. Thus, in instances where VHA might no longer operate a full-service hospital that had once housed a spinal cord injury center, it would need to establish community partnerships to assure veterans would continue to receive the same high quality care.

³⁵ David J. Shulkin, "Why VA Health Care Is Different," *Federal Practitioner*, 33, no. 5 (2016): 9-11, <http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdb726bddcbceea81f27.html>.

availability and quality of care in areas especially needed by veterans, such as mental health and rehabilitation.

Management and Oversight

VHA Care System networks will be built out in a well-planned, phased approach overseen by the new governing board, which will determine the criteria and sequencing for the phases, to ensure effective execution of the strategy. The timing and phasing criteria may include veteran service needs, access issues, quality issues, facility issues, and IT capabilities.

The networks within the VHA Care System will require ongoing management and evaluation of their performance. This process will be the responsibility of VHA management and board, with board oversight of network performance.

The governing board will oversee the budget for the VHA Care System. Local leadership will provide input on funding, and the local networks will determine their funding needs and submit their respective requests to the chief of VHA Care System (CVCS), formerly the undersecretary of health for VHA. The governing board will recommend to Congress the budget required to implement the VHA Care System, with multiyear appropriations. The local network leaders will have the flexibility to manage their respective network budgets based upon local needs. A key element of the new system will be combining a national strategy and local flexibility for managing the budget to allow for effective decision making to ensure veterans' needs are met.

Provider Payment

Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS). MACRA is intended to move the health care industry away from a fee-for-service model to value-based payments.³⁶ Such a system is expected to drive improved quality and lower costs.³⁷

Care Administration

From a strategic perspective, service-connected disabled veterans should receive the highest priority access to the VHA Care System. This principle should guide access to all types and points of care. Veterans with limited financial means should also have high priority. If needed, cost sharing (applicable only to those who are non-service-connected disabled and not financially needy) can provide a means for offering broader choice. The current time and distance criteria for community care access (30 days and 40 miles) should be eliminated. VISN geography should also be eliminated as a factor in determining where veterans can access care. Eligible veterans should be permitted to receive care at any facility and by any provider in the VHA Care System, whether in a veteran's home VISN or not.

Choice and Care Coordination

The topic of choice was the most contentious issue considered by the Commission. Some Commissioners advocated complete choice of providers for veterans, with no requirement for

³⁶ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

³⁷ Ibid.

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care coordination by primary care physicians. Others advocated for a tightly managed model with VHA controlling access to community providers, as is done today. After considering the costs of various design options, the importance of care coordination, and the need for greater veteran access to both primary care and specialty care services, the Commission agreed to the following design principles:

- VHA will establish and credential community networks with a focus on quality of providers, access to comprehensive services, and utilization of VHA resources.
- Veterans will have complete choice of primary care providers within the VHA Care System.
- All primary care providers in the VHA Care System (including VHA providers, DoD and other federally funded providers, and community providers) will coordinate veterans' care.
- Specialty care will require a referral from a primary care provider.
- VHA will assume overall responsibility for care coordination and navigation for all enrolled veterans.

Quality of care must be a core element of network design and consistently monitored with metrics that are routinely used by the private sector. Accordingly, VHA must adopt standards that both ensure networks are composed of high-quality providers and set appropriate expectations of those providers. Critically, all providers in the networks must have fully interoperable IT platforms to allow for complete data exchange. Providers must work together to maximize patients' well-being using evidence-based protocols of care.

Lack of coordination among providers is a major quality and patient-safety issue throughout the U.S. health care system. It is important for VHA to coordinate the care it provides because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.³⁸ Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.³⁹

³⁸ Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>.

³⁹ "The Impact of the Affordable Care Act on VA's Dual Eligible Population," Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016, <http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm>. Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>. Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, 21, no. 5, (2015): 355-362, accessed June 20, 2016, <http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients>. Chuan-Fen Liu et al., "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics," *Health Services Research*, 45, no. 5 part 1, (2010): 1268-1286, accessed June 20, 2016, <http://doi.org/10.1111/j.1475-6773.2010.01123.x>.

VHA Care System will operate as outlined in Table 2 below.

Table 2. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Scope of Provider Networks

In setting up networks within the VHA Care System, VHA must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources (i.e., taxpayer dollars) due to increased utilization or cost shifting. Currently, money VHA spends on expanding choice is not available to spend on other programs and services vital to its mission.⁴⁰

Health plans commonly limit the size and scope of networks as a cost-management tool, offering insurance products with narrow networks (managed care plans) or more open networks (preferred provider plans). Well-managed, narrow networks can maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.⁴¹ Achieving high quality and cost effectiveness may constrain consumer choice. A patient's preferred doctor, clinic, or hospital may not be part of that smaller network or the narrow network may not offer sufficient geographic access for some patients.⁴²

VHA must balance these competing considerations. In doing so, it faces a variety of options. In addition to the scope of networks, for example, is the question of whether and how VHA will play a role in steering patients to different providers within the networks. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans

⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 23 accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴¹ "What Tier Networks Will Mean to You," Ken Terry, accessed June 2, 2016, <http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you>.

⁴² Ibid. U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearing on "Health Care Consolidation"*, 112th Congress, 1st Session, (2011), (Statement of Paul B. Ginsburg, President, Center for Studying Health System Change, Research Director, National Institute for Health Care Reform), accessed June 2, 2016, http://waysandmeans.house.gov/UploadedFiles/Ginsburg_Testimony_9-9-11_Final.pdf.

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often require all specialty care to be preapproved through a referral from a primary care physician. Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. For prospective reviews, patients must receive approval from their health plan before being admitted to the hospital to ensure the admission is clinically appropriate. Plans may also use concurrent utilization or case management for inpatient care to ensure the care and tests ordered and the length of stay in the hospital are appropriate.⁴³

The Commission carefully weighed these issues in recommending an approach. The Commission considered the effect of cost using various configurations of VHA services and community delivered services (CDS). Options considered by the commission include the following:

- **Recommended Option:** This option provides an integrated network of VHA, DoD and other federally funded providers, and community providers, credentialed by VHA. It requires veterans to attain a referral from their primary care provider to access specialty care.
- **CDS Alternative 1:** The main difference between this option and the *Recommended Option* is primary care, inpatient medical and surgical care, and some standard specialty care would not be eligible for CDS networks and would be accessed within VHA unless the *Choice Program* distance exception applies.
- **CDS Alternative 2:** The division of care between VHA providers and CDS network providers would be the same as for *CDS Alternative 1*; however, veterans would only need to consult their primary care provider before seeking specialty care, rather than obtaining a referral.
- **CDS Alternative 3:** This option would combine the broad network in the *Recommended Option*, but would have no referral or consultation requirement; thus, it would be an extremely generous benefits package.
- **Premium Support:** Under this scenario, enrollees who are younger than 65 would choose a subsidized insurance premium with cost sharing. Access to VA services, including special services, would be eliminated.
- **Eligibility Expansion:** Under this scenario the VA health care system would expand to allow all veterans, regardless of priority group.
- **Other-Than-Honorable Discharges:** A policy change for which individuals with other-than-honorable (OTH) discharge is outlined in Recommendation #17. This option would allow temporary eligibility for VA health care to those with an OTH discharge until the adjudication process to determine long-term eligibility took place.

⁴³ Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers," *Health Affairs*, 32, no. 5, (2013): 929-934, accessed June 20, 2016, <http://doi.org/10.1377/hlthaff.2012.1007>. While these approaches can help keep costs down, patients, doctors and hospitals can experience the process as bureaucratic interference in clinical care. To implement utilization management, health plans usually include a strong clinical appeals process that both doctors and patients can access to question the decisions made by administrators.

Below is a more detailed summary of the Commission's *Recommended Option*. Additional information, including cost projections for all of the options above, can be found in Appendix A.

Cost Model for Commission Recommended Option

This option would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VHA. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in a substantially different way than by VHA).⁴⁴ In 2014, 68 percent of care would have been eligible for CDS networks at current VHA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network (i.e., from any provider in the VHA Care System). In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

Both CDS networks and traditional Care in the Community (CITC) are priced at Medicare allowable rates by matching Medicare fee schedule data to VA Health Service Categories.⁴⁵ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities. For care shifting into the CDS networks, we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance; those costs are not modeled.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a provider in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and

⁴⁴ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health, and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

⁴⁵ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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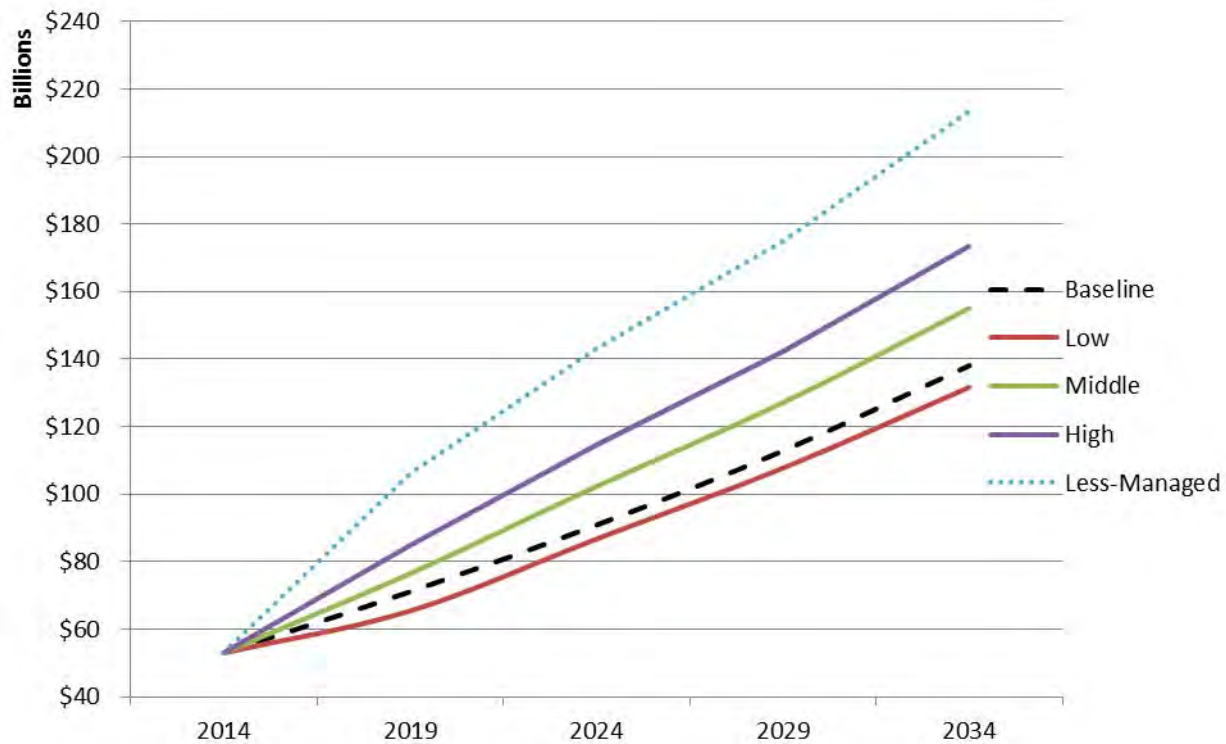
20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was formerly subject to sizable cost sharing with private insurance or Medicare and now would be subject to little, if any, cost sharing associated with VA-financed care.

There are a number of caveats associated with our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects on quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. Finally, estimates do not include administrative costs associated with CDS networks; these costs could be substantial.

Figure 1 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

This model is described more fully in Appendix A, along with models for a range of other options, some of which are previously described in this section. Consult Appendix A for more details on the technical assumptions necessary to understand the results presented here. The assumptions and caveats detailed in Appendix A play a critical role in our estimates, and any deviation from these assumptions could substantially affect the estimates.

Figure 1. Projected Costs of Recommended Option



Mitigating Risks

Choice involves tradeoffs. Reducing drive times to see a doctor may lead to longer wait times, for example, if it induces substantially more veterans to seek more care.⁴⁶ VHA reliance on contracting could also have unintended consequences for already underserved communities. Providers in such communities who join the local VHA network may decide to limit the number of Medicare and Medicaid patients they accept into their practices. In other, highly concentrated health care markets, which are increasingly common throughout the United States, VHA may not be able to contract for care in the community except at higher prices.⁴⁷ Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

Policymakers must also carefully weigh concerns that leaders of seven major veterans organizations expressed in a recent joint letter in which they warned “choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans.”⁴⁸ These organizations do not support providing unfettered choice, and the VSO leaders stated that “any health care reform proposal that elevates the principle of ‘choice’ above all other clinical considerations would have severe consequences for veterans who rely on VA, resulting

⁴⁶ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 284, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁴⁷ David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *Journal of the American Medical Association*, 310, no. 18, (2013): 1964-1970, accessed June 20, 2016, <http://doi.org/10.1001/jama.2013.281675>.

⁴⁸ Garry J. Augustine, Disabled American Veterans et al., letter sent to Commission on Care, April 29, 2016.

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in less ‘choice’ rather than the intended desire for more health care options for many disabled veterans.”⁴⁹

The Commission has addressed this concern in several ways, including the following:

- recommendations to substantially improve VHA operations, thereby enhancing the attractiveness of using VHA providers and facilities by enrolled veterans
- VHA control of network design
- VHA Care System governing board oversight of network execution and phasing
- high standards for community provider participation, including credentialing, military competence, and quality and utilization performance
- VHA oversight of care coordination and navigation
- requirement of primary care referral for specialty care

The Commission recognizes that greater choice of provider can result in higher utilization of health care services, which increases costs. This risk can be mitigated by recommendations in this report that will produce cost savings. To incentivize cost mitigation, all cost savings associated with improved efficiency and operations should be reinvested into the VHA Care System. Examples of cost mitigation strategies include the following:

- recovering third-party payments owed to VHA more effectively
- maintaining VHA as a secondary payer when veterans have other health insurance and treatment is for non-service-connected care
- increasing cost-sharing or changes in eligibility and/or benefit design could also substantially contain the projected costs of increasing provider-choice
- reducing fixed costs of underutilized facilities and services
- managing the supply chain to produce cost savings
- improving facilities to increase provider productivity (e.g., increase in outpatient exam rooms)
- adopting information technology that improves the quality and efficiency of care

Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of VHA, as well as flexible and smart procurement policies and

⁴⁹ Ibid.

contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be locations where VHA quality of care is deficient or capacity is strained.⁵⁰

Where capacity constraints exist within networks, first priority for care should go to those veterans with greatest medical need, followed by service-connected disabled veterans and indigent veterans.⁵¹ VHA should develop processes and procedures for insuring that veterans have the knowledge and assistance they need to make informed health care decision and to navigate effectively through the expanding health care networks. By employing strategies proven by other managed care plans, VHA will find administrative means to guard against inappropriate treatment, wasteful spending, and fraud.

As many surgical and medical procedures that previously required inpatient hospital stays have routinely become outpatient procedures, there continues to be a substantial shift from inpatient to outpatient care.⁵² Consequently, to ensure improved access to care for veterans, the VHA Care System and long-term plans for facilities should focus on creating a robust ambulatory network and reshaping inpatient resources to match expected demand. Additionally, to inform veterans' and providers' decisions and create increased accountability for performance, all VHA and community network providers and facilities must provide transparent information on inpatient and outpatient quality, service, and access using the same performance metrics, including those used by Medicare.

Implementation

Legislative Changes

- Enact legislation amending 38 U.S. Code, Chapter 17 to consolidate existing purchased-care authorities and authorize the SECVA to furnish enrolled veterans needed hospital care and medical services through agreements with providers the SECVA deems meet quality standards the SECVA will establish. Veterans would be eligible for community care on the same basis as for VHA-furnished care, and current wait time and geographic distance criteria should no longer be applicable.

VA Administrative Changes

- Develop national policy to govern local establishment of networks, and in doing so, focus its design and long-term planning on creating a robust ambulatory capability and reshaping inpatient resources to match expected demand.
- Establish standards that community providers must meet to qualify for participation in community networks, to include becoming fully credentialed, meeting patient-access criteria, demonstrating high-quality clinical outcomes and appropriate use decisions, demonstrating military cultural competency, and having capability for interoperable data exchange.

⁵⁰ Information on what medical centers are deficient in their care is available, for example, from the VHA's own Strategic Analytics for Improvement and Learning (SAIL) data.

⁵¹ It would seem prudent to begin such phased development by piloting that effort, and limiting the scope of unfettered choice to service-connected veterans.

⁵² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

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- Establish systems to ensure that all primary care providers in the VHA Care System can effectively coordinate veterans' care.
- Provide veterans navigation services for complex care needs, including information needed by patients and their families for informed decision making about treatments and providers. Navigation services should assist veterans and their families with eligibility, cost-sharing, and other administrative issues.
- Establish policies and procedures to ensure that VHA provider as well as community providers within each network, provide transparent information (using the same metrics) on care-quality, service, and access.
- Eliminate the practice of cross-country referrals if quality care is available locally.
- Employ the most current payment approaches that incentivize quality and appropriate use of health care services.

Other Department and Agency Administrative Changes

- None required.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

Problem

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.⁵³

The Commission Recommends That . . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.⁵⁴ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁵⁵

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

Background

A large part of the VHA’s problem with inadequate clinical support staff derives from its difficulties in hiring, retaining, and training medical support assistants (MSAs). These individuals answer phones, schedule care, and verify health care eligibility, among other duties.

⁵³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁵⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁵ *Ibid.*, 95.

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Congress has recently given VHA the flexibility to offer MSAs market-based pay rates.⁵⁶ VHA is changing cumbersome rules that have made hiring new MSAs exceptionally time-consuming.⁵⁷

VHA is working to resolve its problems with resource allocation in clinics. For example, the agency has committed to increasing use of clinical managers to help medical centers better match resources to patient demand. Widely used by other health care systems, clinic managers enhance operations by ensuring that telephone protocols, scheduling, and clinic workflow are operating at peak efficiency. They also ensure that staff members are assigned appropriate caseloads and are meeting productivity standards and wait time targets and that administrative staff has appropriate training in scheduling, coding, and/or documentation.

Many states have already taken the steps to ensure APRNs have full practice authority. VHA is working to do the same, which will allow a vast increase in the number of VHA clinicians available to treat patients independently.⁵⁸

To effectively manage clinician supply for the inpatient setting, administrators require accurate bed count data. Currently in VHA, data integrity of bed counts is compromised as a consequence of disclosure requirements of Congress. VHA is required by statute to complete a complicated reporting, approval, and notification process when it closes hospital beds.⁵⁹ To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates and thwart planning activities. VHA developed its guidance in part to satisfy the Millennium Act⁶⁰ and other requirements that essentially froze beds at FY 1998 levels.⁶¹

Analysis

VHA has taken a number of measures to address data integrity issues. VHA has started hiring clinical managers to assist in managing resources for effective performance. VHA has made efforts to address problems affecting supply and training of MSAs. Additionally, VHA has recently proposed a rule that would authorize full practice for APRNs working within the agency.⁶²

These measures by themselves, however, will not be sufficient to solve the current problems. VHA must ensure all facilities have enough support positions—both clerical and clinical—to

⁵⁶ Sloan D. Gibson, Deputy Secretary, Department of Veterans Affairs, presentation to Commission on Care, April 18, 2016.

⁵⁷ 38 U.S.C. § 7401(3)(A)(iii).

⁵⁸ Establishing Medication Prescribing Authority for Advanced Practice Nurses, VHA Directive 2008-049, (2008).

⁵⁹ Inpatient Bed Change Program and Procedures, VHA Handbook 1000.01, (2010).

⁶⁰ The Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545, Sec. 301. Title III of the Millennium Act prohibits the secretary from closing in any fiscal year more than 50 percent of the beds within a department medical center unless the secretary first submits to the veterans' committees a justification for such closure and waits to take action on a closure until 21 days after the submission of the report. It also requires the secretary to report annually to the veterans committees on bed closures during the preceding fiscal year.

⁶¹ Extended Care Services, 38 U.S.C. § 1710B(b) requires staffing for extended care to remain at FY 1998 levels.

⁶² "VA Proposes to Grant Full Practice Authority to Advanced Practice Registered Nurses," Department of Veterans Affairs, accessed June 3, 2016, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793>.

enable all clinicians to work at the top of their licenses and to avoid problems with turnover, unexpected staff absences, and surges in patient demand.⁶³

VHA must have authority to pay competitive rates for the personnel it needs. This goal would be accomplished in part by adopting Recommendation #15 of this report for creating a new personnel system under Title 38 for all VHA employees. Currently, for example, clinical managers and practitioners earn far more in the private sector.⁶⁴

As VHA develops improved clinic management tools such as the Health Operations Dashboard, these tools draw from clinical data, patient data, and other sources to allow managers to make decisions using real-time data.⁶⁵ To be effective tools, the data fed into them must be accurate. Relieving VHA from some of the reporting requirements of the Millennium Act will help accomplish effective use of the dashboard for inpatient management.

Implementation

Legislative Changes

- Create a new alternative personnel system under Title 38 authority as mentioned in Recommendation #15.
- Eliminate bed reporting requirements under the Millennium Bill, and require VHA to report new beds as closed, authorized, operating, staffed, or temporarily inactive within 90 days of enactment.

VA Administrative Changes

- Develop policy to allow full practice authority for APRNs.
- Develop leadership tracks, including clinical and group practice managers, for ambulatory settings.
- Develop training programs for medical support assistants (MSAs).
- Modify policy in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, as appropriate.

Other Department and Agency Administrative Changes

- None required.

⁶³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 17-18, accessed June 3 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

⁶⁴ For example, Salaries.com listed a median salary for Clinic Manager III (a manager of a clinic with more than 50 physicians) in Dallas, TX, as \$94,000.⁶⁴ The pay grade assigned for this position is GS-13, which pays about \$73,800 in the first step and increases up to \$96,000. Office of Personnel Management, *Schedule 1 General Schedule*, accessed March 31, 2016, <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/pay-executive-order-2016-adjustments-of-certain-rates-of-pay.pdf>.

⁶⁵ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, presentation to Commission on Care, April 18, 2016.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.

Problem

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁶⁶ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶⁷

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a national revised clinical-appeals process.

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁶⁸ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁶⁹

Background

VHA policy has long required medical centers to operate a patient advocate program to address patient complaints.⁷⁰ In 1996, Congress enacted an eligibility reform statute that, for the first time, gave enrolled veterans access to a uniform benefits package.⁷¹ In implementing that law, VHA conducted a systemwide review of how clinical disputes were handled and consequently instituted an external appeal system in FY 2000. The policy, as outlined in a subsequent directive, allowed VISNs to request external professional boards to conduct impartial reviews of clinical determinations.⁷² That directive also addressed a process for internal clinical appeals. It stated as policy that patients or their representatives who have disputes regarding clinical determinations or services pertaining to provision or denial of care that are not resolved at the facility level must have access to a fair and impartial review of those disputes that could result in a different and/or improved clinical outcome. That policy requires VISN directors to have written policy and procedures in place for how internal appeals are to be handled. Under this policy, VISNs still have authority to request an external review at any time during the clinical

⁶⁶ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶⁷ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁶⁸ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁶⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷⁰ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁷² VHA Clinical Appeals, VHA Directive 2006-057 (2006).

appeals process.⁷³ Although the directive itself expired in 2011, it continues to serve as guidance because it has not been renewed or replaced.

VHA policy directs that all facilities have a patient advocate office to manage and attempt to resolve complaints. That office, which can serve as the liaison between patients and clinicians, is generally the first stop for veterans who are dissatisfied with a clinical decision.⁷⁴ If a clinical issue is not resolved at the point of the service, it generally goes to the facility director, who is to provide veterans written notification of the facility's decision and inform veterans about the VISN's appeals process. Under the same policy directive, veterans may appeal the facility decision to the VISN director. That official, or a clinical review panel that he or she establishes, is to render a decision within 30 days (or 45 days if the director requests an external clinical review).⁷⁵ Should the VISN director agree with the facility, he or she must notify the veteran that the decision is final or may refer the matter to a VACO office to arrange for an external review.⁷⁶

The VHA process does not appear fully comparable to procedures required under other federal and federally-supported health care programs. For example, under the Affordable Care Act, health care plans are required to provide external reviews to beneficiaries whose internal appeals have been denied.⁷⁷ Unlike those and other appeals processes, veterans have no right to external review; such review is at the discretion of the VISN director. Medicare has an extensive review process for clinical disputes between its managed care organizations and beneficiaries. Beneficiaries have the right to an internal appeal with an option for an expedited review, an internal reconsideration of the initial review, an independent review, a hearing with an administrative law judge, a review by the Medicare Appeals Council and, finally, a federal district court review.⁷⁸ Medicaid has requirements for localities to review appeals from its beneficiaries and for states to offer timely access to fair hearings to determine whether managed care organizations have denied or terminated medically necessary care.⁷⁹ Although VHA's timeframe for decision making seems reasonable, the national policy makes no provision for an expedited review, unlike Medicare managed care organizations and plans providing health benefits to federal employees. VHA's policy is also silent on meeting with veterans to hear their cases much less hold hearings during any point of the appeal. Unlike Medicaid, VHA also lacks any provision for service-continuity while the matter is being appealed. The Commission recommends that VHA develop a revised clinical-appeals process that provides veterans protections at least comparable to those afforded patients under other federal and federally-supported programs, including, at a minimum, a right to an external review at the veteran's discretion.

⁷³ Ibid.

⁷⁴ VHA Patient Advocacy Program, VHA Handbook 1003.4, (2005).

⁷⁵ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁷⁶ Ibid.

⁷⁷ "Appealing Health Plan Decisions," Department of Health & Human Services, accessed June 1, 2016, <http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html>.

⁷⁸ Centers for Medicare & Medicaid Services, *Managed Care Appeals Flowchart CY2016*, accessed May 26, 2016, <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart.pdf>.

⁷⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

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Implementation***Legislative Changes***

- None required.

VA Administrative Changes

- Convene an interdisciplinary panel to assist in developing a revised clinical-appeals process and policy that includes all care provided within the VHA Care System, to include representation from Patient Care Services, MyVA's Patient Advocates and Veterans Experience Program, the Office of Equity, the National Center for Ethics in Health Care, and the Office of Access and Clinical Administration. VHA should have that panel examine and offer recommendations regarding the following:
 - Each level of review in the clinical-appeals process – from the facility's initial reconsideration to a final decision by the VISN director to assess the fairness and impartiality in those processes compared to Medicare Managed Care and Medicaid appeals processes and private-sector managed care providers' best practices.
 - Whether VHA should establish a uniform national clinical appeals process.
 - The advisability of requiring review panels consisting of individuals such as attorneys, clinicians, case managers, patient advocates, and administrators to review clinical appeals.
 - Whether hearings or judicial reviews are appropriate at any level of the appeals process.
 - Whether resolutions of clinical appeals are equitable for all types of veterans (service-connected or non-service-connected, by racial or ethnic group, by age, or gender).
 - Options for increasing veterans' awareness of the clinical-appeals process.
- Publish the new clinical appeals policy and process for comment and input by veterans, VHA business partners, and other stakeholders.
- Once the new policy is finalized, VHA must train staff on the new process.

Other Department and Agency Administrative Changes

- None required.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

Problem

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁸⁰

VHA has a program of systems engineering — the Veterans Engineering Resource Center (VERC) — that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

Background

To become a truly veteran-centric care provider, VHA is working to become a learning organization.⁸¹ Learning organizations focus on worker competency rather than on rules compliance. Instead of using results to identify high- and low-performers, VHA will use this information to identify opportunities to intervene with training or other resources to improve employees' performance universally. Employees and patients should benefit from this approach because it values listening and encourages risk taking and innovation.

VA and VHA have adopted the tenets of LEAN Six Sigma as a systemic change approach to move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control approach to systemic change. LEAN, initially used by manufacturers, has been used successfully by many health care organizations.⁸² The goal of implementing LEAN practices is to eliminate waste, ensuring that any work done adds value. The MyVA plan calls for MyVA districts and the Office of Policy and Planning to ensure the transmission of best practices and the adopting of LEAN throughout the enterprise to provide a more comprehensive view of quality that balances a results-oriented approach with more process-

⁸⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical)*, 14 and A-2 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸¹ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

⁸² MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 12, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

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oriented practice.⁸³ So far these efforts have been guided by trial and error, rather than directives and adopting a LEAN, process-driven model.⁸⁴ VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology.

VHA will have to use VERC staff and other trained staff members to ensure that principles of LEAN Six Sigma are applied at every level of the system. VERC has the mission to propose, develop, and facilitate innovative solutions to challenges within VHA health care delivery through the integration of systems engineering principles.

With VERC's reach already extending into access to care, health policy, population health, LEAN management, business systems, clinical systems, safety systems, and innovation, all other programs and initiatives become redundant or ancillary. VHA must assess its new system for best practice diffusion to ensure that selected practices are being appropriately scaled. This goal can best be achieved by collapsing all related efforts into VERC.

There are a number of emerging best practices within the health care sector that apply to all aspects of VHA – health care capabilities, staffing, access, supplies, and facilities – and involve the testing, dissemination, and application of procedures or systems that have been shown to improve approaches, processes, or systems.⁸⁵ VHA needs to have the opportunity to fully leverage and build on institutional strengths by implementing best practices.

VHA has recently developed the Diffusion of Excellence Initiative, which is designed to serve as the mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best practice sharing and innovation.⁸⁶ Its organizational structure includes a governance board chaired by the USH, a Diffusion Council, and action teams responsible for implementing promising practices.

VHA also has many business lines charged with disseminating best practices information, including VERC, Systems Redesign SharePoint – Center for Improvement Education, VA Center for Innovation, MyVA – Best Practices in LEAN, MyVA Blog, MyVA Performance Improvement Hub, Knowledge Management System–Improvement in Action (I-ACT), VA Idea House, VA Pulse: Promising Practices Consortium, Evidence-based Synthesis Program (ESP), Quality Enhancement Research Initiative (QUERI), the Annual Conference on the Science of Dissemination and Implementation, and the Diffusion of Excellence Initiative.

Analysis

LEAN Six Sigma offers VHA a methodology to effect change and VERC offers VHA the agents to lead its implementation. VHA must consolidate its transformational tools, including its best

⁸³ MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 21, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

⁸⁴ The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical), viii accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸⁵ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 41, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁸⁶ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

practice repositories within VERC. The VERC uses a systemic change process to streamline workflow and procedures by eliminating waste and redundancy to ensure that every step in the process adds value. The VERC offers services to VHA health care facilities upon request, but VHA would substantially benefit if the service was authorized to perform outreach to ensure awareness across the VHA Care System.⁸⁷

Until developing the Diffusion of Excellence Initiative, VHA lacked a uniform way to scale and optimize best practices throughout the enterprise. Although the Diffusion Initiative is initially targeting best practices from within VHA, to be successful, a long-term plan should also allow for the adoption of best practices from the private sector and other government sectors (e.g., the Medicare program related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels to reflect respective differences in provider supply, veteran needs, and marketplace characteristics.⁸⁸

VHA has multiple offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing they exist.⁸⁹

VHA's National Leadership Council has proposed consolidating these best practice repositories under the VERC, which now serves within the Office of Organizational Excellence. Until recently, VERC has been underutilized because it is not known throughout the enterprise.⁹⁰

QUERI is a system that identifies evidence-based care practices that may be scaled for systemwide implementation. QUERI was integrally involved in the transformation of VHA from a largely hospital-based system to one centered on primary care⁹¹ and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated veterans' reliance on VHA was strongly correlated to economic factors such as unemployment rates and availability of other health care coverage.⁹²

VA should use a systematic, continuous performance improvement process to improve access to care. Although many VA facilities achieve very high-performance ratings on key access and quality measures, a systematic effort is needed to improve performance. These efforts need to

⁸⁷ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁸⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 28, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf

⁸⁹ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁹⁰ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹¹ "HSR&D Perspectives Blog, QUERI Corner: Surviving and Thriving," Amy Kilbourne, QUERI Program Director, January 20, 2015, accessed from VA Intranet, April 4, 2016, <http://vawww.blog.va.gov/hsrd/category/queri-corner/>.

⁹² Christine Yee, Austin Frakt, and Steven Pizer, U.S. Department of Veterans Affairs, "Economic and Policy Effects on Demand for VA Care," Partnered Evidence-based Policy Resource Center, Policy Brief, March 2016, accessed June 21, 2016, http://www.queri.research.va.gov/partnered_evaluation/YeeFraktPizer.pdf.

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be embedded into routine use across the VA system. The best solutions should be adjusted to reflect local needs and designed to respond to veterans' preferences, needs, and values.⁹³

A systems approach to health care is “one that applies scientific insights to understand the elements that influence health outcomes, models the relationships between those elements, and alters design, processes, or policies based on the resultant knowledge in order to produce better health at lower cost”⁹⁴ and would benefit VA greatly, especially with resources like VERC to serve as a guide.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.⁹⁵ A variety of quality improvement organizations are involved in establishing and maintaining standards in health care as well as developing measures for the monitoring and assessment of these standards, including The Centers for Medicare & Medicaid Services, the Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum.⁹⁶

The tools of operations management, industrial engineering, and systems approaches are successful in increasing process gains and efficiencies. In particular, a wide range of industries have employed systems-based engineering approaches to address scheduling issues, among other logistical challenges.⁹⁷

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Consolidate all best practices and continuous improvement portals under VERC to provide a more accessible and comprehensive approach to best practice sharing and adoption.

Other Department and Agency Administrative Changes

- None required.

⁹³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 110 and 297 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁹⁴ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹⁵ Ibid., 15.

⁹⁶ Ibid., 60.

⁹⁷ Ibid., 27-28.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

Problem

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.⁹⁸

A systematic review of VHA in 2015 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.⁹⁹ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

Background

It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.¹⁰⁰

Across the nation, health care systems are raising awareness about health care equity, inequality, and disparities.¹⁰¹ The growing incidence of health care disparities and inequities is said to be ascribed to individual and collective cultural indifference on the part of health care

⁹⁸ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁹⁹ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹⁰⁰ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

¹⁰¹ Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, accessed April 5, 2016, <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

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providers and the health care system as a whole.¹⁰² A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on racial or ethnic group, gender, age, sexual orientation, military era, geographic location, religion, socioeconomic status, mental health, cognitive/sensory/physical disability, and other characteristics historically linked to discrimination or exclusion.¹⁰³

The United States is becoming increasingly diverse, with racial and ethnic minorities making up more than 36 percent of the population.¹⁰⁴ Indicators of overall health, such as life expectancy and infant mortality, have improved for most Americans; however, some minorities still face comparatively greater likelihood of preventable disease, death, and disability.¹⁰⁵

Although the country's veteran population is projected to decline from 22 million to 14.5 million by 2040, the percentage of minority veterans will increase from 20 percent to 34 percent during the same period.¹⁰⁶ Currently, African Americans make up 11 percent of the veteran population, and Hispanics, 6 percent.¹⁰⁷

Survey data show that minority veterans use VA health care more than White veterans, as shown below:¹⁰⁸

- African American: 38 percent
- Hispanic: 34 percent
- American Indian/Alaska Native: 38 percent
- White: 32 percent

¹⁰² G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," *JHHA* (2011), 146.

¹⁰³ "Office of Health Equity," U.S. Department of Veterans Affairs, accessed June 12, 2016, <http://www.va.gov/HEALTHY/index.asp>.

¹⁰⁴ "Minority Health and Health Equity – CDC," Centers for Disease Control and Prevention (CDC), accessed March 28, 2016, <http://www.cdc.gov/minorityhealth/index.html>.

¹⁰⁵ *Ibid.*

¹⁰⁶ National Center of Veterans Analysis and Statistics, *Minority Veterans 2011 Report*, May 2013, accessed April 6, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.

¹⁰⁷ U.S. Census Bureau, *American Community Survey, Public Use Microdata Sample (PUMS)*, 2011. Department of Defense, *Population Representation in the Military Services Fiscal Year 2011 Report*, accessed April 5, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf

¹⁰⁸ Reliance projections here are based on ambulatory care utilization. Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 82, accessed May 19, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

Survey data on racial and ethnic minority veterans' use of VHA health care offer revealing insights on current equity issues:¹⁰⁹

- Fifty-seven percent of African Americans indicated they are more likely to use VA as their primary source of health care as compared to 45 percent of Whites.¹¹⁰
- The percentage of African Americans who reported they use VA for all or most of their care needs is 18 percent higher than the percentage of Whites who do so.¹¹¹
- A higher percentage of Whites assessed their health to be good or excellent than did African Americans.¹¹²

Analysis

VHA Office of Health Equity

VA created the OHE in 2012 to identify health care inequities, understand the cause of them, and bring to clinical practice interventions intended to reduce disparity drivers within VA. OHE partners with other VA offices, federal government offices, and nongovernment institutions with missions aimed at promoting health equity.¹¹³ OHE has substantial stakeholder involvement from minority veterans groups, including the Advisory Committee on Minority Veterans (ACMV), rural veterans groups, women veterans, and the Office of Diversity and Inclusion (ODI).¹¹⁴ A staunch internal partner and stakeholder of OHE, ODI's mission is to foster a diverse workforce and an inclusive work environment. The OHE and ODI missions intersect with ODI's special emphasis programs, intended to engage affinity groups and agencies to raise the awareness of the importance of diversity and demonstrate VA's commitment to a diversity model.¹¹⁵

OHE's foundational work included updated systematic reviews and data analyses that not only revalidated VA's previous findings on health care inequities, but also identified more areas of health care disparity among veterans. For instance, hepatitis C virus (HCV) was noted to have disparate effect on racial/ethnic minority veterans and Vietnam-era veterans. Additionally, OHE convened stakeholders and worked with the Health Equity Coalition to develop the VHA Health Equity Action Plan (HEAP), which aligns with the VHA Strategic Plan Objective 1e: Quality & Equity, which states, "Veterans will receive timely, high quality, personalized, safe effective and equitable health care irrespective of geography, gender, race, age, culture or sexual

¹⁰⁹ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹⁰ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 85, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Department of Veterans Affairs, Office of Health Equity, *US Department of Veterans Affairs Office of Health Equity Mission and Accomplishments*, accessed March 30, 2016, http://www.va.gov/HEALTHEQUITY/docs/OHE_Mission_and_Accomplishments_November_2015.pdf.

¹¹⁴ "Office of Diversity and Inclusion (ODI)," Department of Veterans Affairs, accessed May 13, 2016, <http://www.diversity.va.gov/>.

¹¹⁵ "Office of Diversity and Inclusion (ODI), Special Emphasis Programs," Department of Veterans Affairs, accessed May 17, 2016, <http://www.diversity.va.gov/programs/default.aspx>.

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orientation.”¹¹⁶ HEAP aims to address five strategic areas: awareness, leadership, health system and life experience, cultural and linguistic competency, and data that are vital for effectively implementing its mission. HEAP implementation strategies are conceptually modeled after the goals and strategies of the National Partnership for Action to End Health Disparities’ National Stakeholder Strategy for Achieving Health Equity sponsored by the U.S. Department of Health and Human Services.¹¹⁷

Despite OHE’s best efforts, HEAP was not fully implemented because VHA leadership failed to establish it as a strategic priority with adequate staffing, resources, and support, and the departure of the then USH, a champion for health equity. These factors led to the reduction of OHE staffing from 8 to 2 FTEs in FY 2013 and a realignment of OHE to several layers down in the organization. As a result of an FY 2015 budget reduction, OHE continues to operate with a two-person staff.¹¹⁸ The reduced staffing level is inadequate to meet the requirements and mission of the office.

OHE has a broad and challenging mission, particularly given the number of minority veterans who rely on VA health care, the health risks in those populations, and the health care disparities those populations experience.¹¹⁹ OHE faces serious challenges in its efforts to carry out its action plan and to realize its broad and critical mission, challenges intensified by its limited staffing and the downgrade of this office within VHA’s organization structure. These include the following:¹²⁰

- lack of quality data on vulnerable populations and disparate health outcomes
- health equity projects that have been delayed or halted due to staff and resource limitations
- lack of data on the overall impact of existing health equity initiatives at facilities
- lack of common definitions on vulnerable populations and health equity concepts

Notwithstanding its limited staffing, OHE has compiled a substantial record of accomplishments. Among its initiatives, OHE embarked in 2015 on a strategy of working collaboratively with the Quality Enhancement Research Initiative (QUERI) to advance health equity. The two collaborative efforts focus on using a population health approach to examine the distribution of diagnosed health conditions, mortality, and health care quality across the VA health care system. A fully staffed OHE would have the capability of creating additional

¹¹⁶ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

¹¹⁷ “National Partnership For Action (NPA), National Stakeholder Strategy for Achieving Health Equity,” U.S. Department of Health & Human Services, accessed May 16, 2016, <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

¹¹⁸ Uche S. Uchendu, Executive Director, OHE, briefing to Commission on Care, December 14, 2015.

¹¹⁹ “Management Brief no. 99,” Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99. Somnath Saha et al., “Racial and Ethnic Disparities in the VA Health Care System: A Systematic Review,” *Journal of General Internal Medicine*, 23, no. 5, (2008): 654-671.

¹²⁰ Uche S. Uchendu, Executive Director, Office of Health Equity, briefing to Commission on Care, December 14, 2015.

analytical tools to manage the daily health care equity program and provide needed services to advance health equity.¹²¹

Health Care Disparities Among Minority Veterans

Minority groups are at increased risk of major, life-threatening health conditions, as documented in a substantial body of research¹²² and illustrated in the table below:¹²³

Table 3. Major Health Conditions in Racial/Ethnic Minority Groups

Major Health Conditions Identified and Examined in Racial/Ethnic Minority Groups		
African Americans	Hispanics	American Indian or Alaska Natives
<ul style="list-style-type: none"> ▪ Colon Cancer ▪ HIV ▪ Chronic Kidney Disease ▪ Diabetes ▪ Stroke ▪ Venous Thromboembolism (VTE) ▪ Cancer ▪ Heart Disease 	<ul style="list-style-type: none"> ▪ Hepatitis C ▪ Cancer ▪ Heart disease 	<ul style="list-style-type: none"> ▪ Major Non-cardiac Surgery ▪ Pregnant Women with PTSD

HCV is more prominent among some racial and ethnic minority veterans and they are less likely to receive treatment for HCV. In VHA, some racial and ethnic minorities diagnosed with HCV are disproportionately more at risk for having associated liver disease (ALD). Disparities among veterans in the incidence of HCV, illustrated in the graphs below, show the important policy and resource implications for VA.¹²⁴

¹²¹ Ibid.

¹²² Andy I. Choi et al., “White/Black Racial Differences in Risk of End-Stage Renal Disease and Death,” *The American Journal of Medicine*, 122, no. 7, (2009): 672-678. Andy I. Choi et al., “Racial Differences in End-Stage Renal Disease Rates in HIV Infection with Diabetes,” *Journal of the American Society of Nephrology*, 18, no. 11 (2007): 2968-2974. Hashem B. El-Serag et al., “Racial Differences in the Progression to Cirrhosis and Hepatocellular Carcinoma in HCV-Infected Veterans,” *The American Journal of Gastroenterology*, 109, no. 9, (2014): 1427-1435. Cleo A. Samuel et al., “Racial Disparities in Cancer Care in the Veterans Affairs Health Care System and the Role of Site of Care,” *American Journal of Public Health*, 104, Supplement 4, (2014): S562-571.

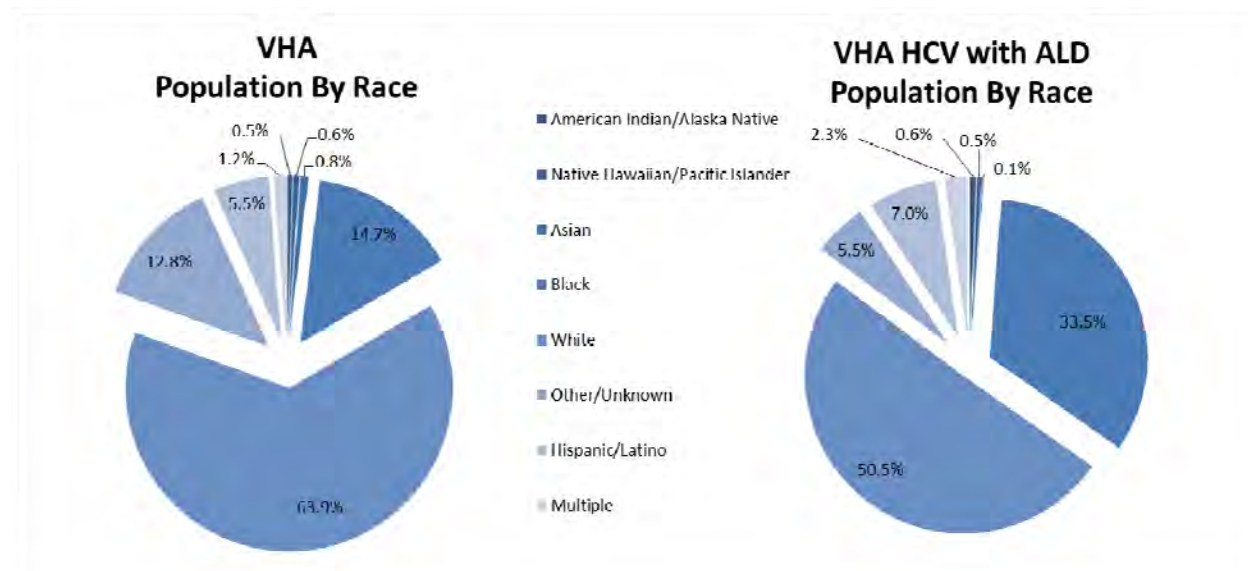
¹²³ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016,

<http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹²⁴ Department of Veterans Affairs, Office of Health Equity, *Hepatitis C Factsheet, Hepatitis C, Advanced Liver Disease & Health Care Disparities*, accessed May 25, 2016, <https://github.com/departments-of-veterans-affairs/VHA-Asset/raw/master/Hep%20C%20FACT%20SHEET%20FINAL%2010162015.pdf>.

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Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus



A recent review of evidence related to racial and ethnic differences in outcomes for VA patients showed moderate- and low-strength evidence suggestive of gaps in morbidity and mortality outcomes among vulnerable veteran populations with major health conditions. These data, presented in the table below, highlight targets for further research.¹²⁵

Table 4. Comparison of Health Outcomes by Race

Comparison	Worse Health Outcomes For Racial Minority Group Relative to Reference Population (usually White)
Moderate-Strength Evidence (based on VA data from the early 2000s)	
African American v. White	Increased end-stage renal disease among chronic kidney disease patients
	Increased end-stage renal disease among HIV patients (with or without diabetes)
	Decreased colon cancer survival 3 years after diagnosis
Hispanic v. White	Increased cirrhosis and hepatocellular carcinoma among hepatitis C patients
Low-Strength Evidence (each finding supported by only a single retrospective study with important methodological limitations)	
African American v. White	Increased mortality among diabetes patients
	Increased risk of preterm birth among PTSD patients
	Increased mortality at 2 years post-hospitalization among stroke patients
	Decreased survival 3 years after diagnosis of rectal cancer
American Indian or Alaskan Native v. White	Increased risk of 30-day post-op mortality after major noncardiac surgery
	Increased risk of preterm birth among PTSD patients
Combined other racial/ethnic minority groups v. African American	Increased injury-related death among alcohol use disorder patients

¹²⁵ “Management Brief no. 99,” Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99.

OHE's focus, health equity, is intended to combat health care disparities, namely, the differences in the preventive, diagnostic, or treatment services offered to veterans with similar health conditions. Health care disparities stem from a combination of complex factors occurring at the level of the health system, provider, and patient.¹²⁶ Health care disparities can result from biological differences among various racial/ethnic groups as well as from social disparities,¹²⁷ also termed social determinants, which stem from such factors as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, and are causally linked to subsequent adult disease.¹²⁸ For example, poor-quality housing poses a risk of exposure to many conditions that can contribute to poor health, such as indoor allergens that can lead to and exacerbate asthma, injuries, and exposure to lead and other toxic substances.¹²⁹ Social determinants that drive health disparities among African Americans, Hispanics, American Indians, and Alaska Natives include race/ethnicity; gender; age; geographic location; religion; socio-economic status; sexual orientation; military era; disabilities, including cognitive, sensory, or physical; and other characteristics historically linked to discrimination or exclusion. Positioned in a department that also provides benefits that fall within the social determinants of health, OHE is in a unique position to improve veterans' health.

The Henry Ford Health System (HFHS) is an example of a health system that is committed to health equity and one VHA can emulate as it works to improve health equity. HFHS is a nonprofit, vertically integrated health care organization that serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area.¹³⁰ HFHS's comprehensive health equity staff has a health care equity campaign with a goal of increasing knowledge, awareness, and opportunities to ensure health care equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large.¹³¹ The campaign is also intended to make health care equity a key, measurable aspect of clinical quality.¹³² A similar effort by VHA would create a system for tracking improvement of health equity over time and holding the organization accountable for ongoing efforts in this regard.

The VHA strategic plan for FY 2013–2018 states that veterans will receive timely, high quality, personalized, safe, effective, and *equitable* health care, irrespective of geography, gender, race, age, culture, or sexual orientation.¹³³ Although that statement signals a sensitivity to health equity, the level of funding support for the VHA office with the lead role in promoting health equity and reducing disparity calls into serious question the leadership priority and commitment to that strategic goal. VHA leadership must make health care equity a strategic

¹²⁶ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹²⁷ James H. Price, Molly A. McKinney, and Robert E. Braun, *Social Determinants of Racial/Ethnic Health Disparities in Children and Adolescents*, accessed April 1, 2016, <http://www.sophe.org/Sophe/PDF/Webinars/20120416151902.pdf>.

¹²⁸ Ibid.

¹²⁹ "What Drives Health," Robert Wood Johnson Foundation, Commission to Build a Healthier America, accessed April 1, 2016, <http://www.commissiononhealth.org/WhatDrivesHealth.aspx>.

¹³⁰ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

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priority by directing and funding the implementation of VHA HEAP nationwide and designating a leader and clinical champions within each VISN and VAMC, as a designated full-time equivalent (FTE), providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successfully achieve its mission and goals, to include providing additional needed funding to support implementation of the VHA HEAP; and ensuring OHE reports to the chief of VHA Care System (CVCS).

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champion within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues.
- Reestablish OHE staffing based on the 2011 VHA Health Care Equality Workgroup recommendations to enable OHE to fulfill VHA's vision to provide appropriate individualized health care to each veteran in a method that eliminates disparate health outcomes and assures health equity. Action required includes, but is not limited to, funding FTE staffing levels commensurate with the scope and size of other federal offices of health equity.
- Reinstate OHE within the office of the CVCS to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.¹³⁴
- Monitor and evaluate the department's success in implementing HEAP.

Other Department and Agency Administrative Changes

- None required.

¹³⁴ Department of Veteran Affairs, Health Equity Coalition Request for VHA Commitment, February 2016. Principal Deputy Under Secretary of Health Memorandum, Health Equity Coalition, March 21, 2013.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Problem

Veterans who turn to VHA to meet their health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern ambulatory health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of these barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks, as proposed in

Recommendation #1 holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital

structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of the build out of the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as much control as possible to drive the process so that all facility plans are fully integrated with the strategic vision for the VHA Care System.

Background

Most VHA health care centers were designed when care was focused on inpatient hospital treatment. VA acquired some of these facilities nearly a century ago from the Public Health Service; many others were transferred from the War Department shortly after World War II.¹³⁵ The average VHA building is 50 years old – five times older than the average building age of not-for-profit hospital systems in the United States.¹³⁶ Most of its facilities were designed to meet markedly different needs than today's health care facilities. Some were tuberculosis

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission process to be implemented as soon as practicable. The Commission recommends that the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

¹³⁵ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, vi, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

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sanatoriums, others for years primarily housed patients with mental health conditions.¹³⁷ Although many have been extensively renovated, the renovations themselves are now outdated, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities showed that VHA facilities average a *C minus* score,¹³⁸ meaning much of the total facilities portfolio is nearing the end of its useful life, and 70 percent of facility correction repairs are being made on Grade D facilities.¹³⁹

During the past 8 years, veteran inpatient bed days of care have declined nearly 10 percent as outpatient clinic workload has increased more than 40 percent.¹⁴⁰ Current facilities, whether they have been maintained adequately or not, often do not support contemporary ambulatory care needs, with outpatient care often housed in converted inpatient spaces.

Through its capital planning methodology, VA has identified more than \$51 billion in total capital needs during the next 10 years.¹⁴¹ Capital funding during the past 4 years has averaged just \$2 billion annually.¹⁴² If funding levels remain consistent during the next 10 years, anticipated funding would be \$25 billion to \$35 billion less than the \$51 billion capital requirement.¹⁴³ VA planning must also take account of demographic changes and population migration that have led to underutilized medical centers in some areas of the country, and a need for new capacity in others.¹⁴⁴

Analysis

New Planning Paradigm

As the department acknowledged, “VA’s health care delivery model must . . . change.”¹⁴⁵ Importantly, it recognizes that “No organization can excel at every capability,” and stated “[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers.”¹⁴⁶ The acknowledgement that VHA can best serve veterans by focusing on its core competencies and unique capabilities, while relying more heavily on purchased care holds important implications for VHA’s capital needs and capital asset management. Rather than assessing VHA’s capital needs by reference to an expectation that each VA medical center, or constellation of medical centers, must provide virtually all needed hospital and medical services, capital needs must be redefined within the framework of the VHA Care System’s high-performing integrated community health care networks. VHA must determine what services it will continue to provide directly in a given community before it can determine its respective infrastructure needs. In identifying its core competencies, unique

¹³⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 27, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, 46.

¹⁴¹ *Ibid.*, 17.

¹⁴² *Ibid.*, 18.

¹⁴³ *Ibid.*, 18.

¹⁴⁴ *Ibid.*, 59-61.

¹⁴⁵ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 18, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

¹⁴⁶ *Ibid.*

capabilities, and needed ancillary services, VHA would be setting at least a general framework through which network and local planners could assess where and how needed services would be delivered, including which would be provided directly by VHA and which through purchased care. Such a mapping exercise would be a first step in developing the integrated community health care networks.

The shape of an integrated delivery network will take different forms in each service-area, and planning and developing those local networks will necessarily require assessing VHA's physical plant and capacity in a new light. That reassessment process would inform capital planning, and must take account of at least three distinct needs: capital needs associated with buildings VA would retain; meeting new or replacement space needs; and the disposal of unused, unneeded property.

Property Divestiture

VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission: caretaker of an extensive portfolio of vacant buildings. As recently as October 2015, VA reported that its inventory includes 336 buildings that are vacant or less than 50 percent occupied, requiring it to expend patient-care funds to maintain more than 10,500,000 square feet of unneeded space.¹⁴⁷ The SECVA recently testified that it costs VA an estimated \$26 million annually to maintain and operate vacant and underutilized buildings.¹⁴⁸

VA's authority to carry out property-management is circumscribed in law,¹⁴⁹ and the department at times faces insurmountable challenges in either attempting to repurpose or divest itself of underutilized or vacant property.¹⁵⁰ In contrast to more rigid property-divestiture provisions, VA has had success in using a flexible authority to enter into long-term leases of VA property for *enhanced use*.¹⁵¹ This authority allows VA to lease underutilized capital

¹⁴⁷ Ibid., 92.

¹⁴⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

¹⁴⁹ Authority for Transfer of Real Property; Department of Veterans Affairs Capital Asset Fund, 38 U.S.C. § 8118 Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122. For example, under section 8118, VA must receive at least full market value in transferring property, unless the property is transferred to an entity that provides services to homeless veterans, and any proposed transfer is subject to the requirement in section 8122 that VA first hold hearings, notify Congress in advance, and not proceed for a specified period. VA property can be determined to be "excess," though under 38 U.S.C. § 8122(d)(1), VA may not make such a declaration unless the property is not suitable for use for provision of services to homeless veterans and reviewed for possible disposal under the Property Act Disposal, administered by the General Services Administration (GSA) (40 U.S.C., subchapter III). GSA employs a rigorous, multistep process to assure that the asset is not needed by any other Federal agency. Under the Act, the agency disposing of the asset is responsible for funding disposal costs, including environmental remediation. GAO has testified that properties remain in an agency's possession for years and continue to accumulate maintenance and operations costs because of the legal requirements agencies must meet and the length of the process. (U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>).

¹⁵⁰ With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces obstacles and delays in efforts to divest itself of these properties; VACO staff report that stakeholder concerns have been obstacles.

¹⁵¹ Enhanced-Use Leases of Real Property, 38 U.S.C. §§ 8161-8169, as amended by Veterans Millennium Health Care and Benefits Act, Section 208, Pub. L. No. 106-117, 113 Stat. 1545 (1999), as in effect when GAO testified on this successful program (U.S. Government Accountability Office, *VA Real Property: VA Emphasizes Enhanced-Use Leases to*

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assets to private-sector entities for up to 75 years to develop housing for homeless and at-risk veterans and their families. Most recently, however, Congress imposed severe limits on that leasing authority.¹⁵²

Ongoing Capital Needs

Establishing a transformative new health care delivery model that relies more on purchased care will not eliminate the need for new clinics, facility renovations, and remedying VHA space deficiencies. The scope of those needs must still be determined in light of a proposed new delivery system, but they cannot be ignored. The *Independent Assessment Report* catalogued the challenges of managing and operating VA's capital program and the need to deploy best practices to improve total performance, and clearly address the importance of more modern facilities for delivering high quality care.¹⁵³

Of particular concern is an apparent breakdown in the process of bringing new clinics online and renewing the leases of existing clinics. With current law requiring congressional approval of any lease with an average annual rental of more than \$1 million,¹⁵⁴ a Congressional Budget Office (CBO) ruling¹⁵⁵ has upended the approval process and halted the leasing program.¹⁵⁶ Indicative of the scope of the problem, VHA's then USH testified in 2013 that VA, since 2008, had opened 180 leased medical facilities, 50 of which required authorization as major leases.¹⁵⁷ Currently, 24 major VA leases are in limbo.¹⁵⁸

Manage its Real Property Portfolio, GAO-09-776T (Washington, DC, 2009), <http://www.gao.gov/assets/130/122697.pdf>. For example, VA has authority to outlease its facilities for up to 3 years, but may not retain the proceeds of any such leasing (Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122(a)(1)). U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>.

¹⁵² Before the sunset of that authority in 2011, VA could enter into such a long-term lease if (1) at least part of the property's use would contribute to VA's mission, (2) the lease would not be inconsistent with that mission; and (3) the lease would enhance the use of the property (Enhanced-Use Leases, 38 U.S.C. § 8162(a)(2)). Congress reauthorized enhanced-use leasing, but limited it to a single use: the development of supportive-housing for veterans who are homeless or at risk of homelessness (Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Sec. 211, Pub. L. No. 112-154, 126 Stat. 1165 (2012).)

¹⁵³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁵⁴ Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104.

¹⁵⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 42 (June 27, 2013) (Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁶ *Ibid.* CBO maintains that the structure of VHA's lease transactions—the lease of a facility, designed by and built for VHA, and for which payments retire most or all of the debt over the life of the lease—is in the nature of a governmental purchase, and, as such, the full cost of acquiring the facility should be budgeted up front, rather than spread over the duration of the lease. As budget rules generally require that Congress offset that aggregate cost, CBO's position has had the effect of blocking what had previously been a manageable funding process.

¹⁵⁷ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 44 (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

One of the primary benefits of leasing is that it can provide flexibility and speed.¹⁵⁹ But the time VHA has required to execute a lease, from planning through to activation, has taken almost 9 years in the case of a major lease,¹⁶⁰ in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.¹⁶¹

In acknowledging the magnitude of the challenges associated with VA's capital program and the budget constraints within which VA is operating, the *Independent Assessment Report* includes a suggestion that transformative options be considered, to include alternative vehicles for capital delivery such as public-private partnerships.¹⁶²

Capital Asset Management

Capital asset management itself requires reengineering. Facilities-related functions are dispersed through VA, resulting in a lack of accountability for outcomes, a mismatch between planning efforts and funding decisions, and separation of project execution and facilities management,¹⁶³ suggesting a need for transformative changes in operations.¹⁶⁴

In its work to foster transformation, department officials have recognized many organizational and process challenges that require priority attention, including the need to realign its infrastructure, identify new (private) sources of financing, streamline investment decision making and contracting, and improve the management of capital projects.¹⁶⁵ Organizational change aimed at streamlining and better aligning core processes is vital to effective operation of VA's facilities programs.

Capital-Asset Imperatives

The planning and development of a new delivery model centered on establishing integrated networks of care has major implications for identifying, planning for, and realizing VHA's capital needs. Greater reliance on community care, inherent in that model, establishes a new set of imperatives, specifically, a need for

- facility realignment
- more effective means of repurposing or other divestiture of unneeded buildings and land
- new, more effective tools to meet VHA's need for new clinic capacity and major construction
- more effective management of VHA's capital needs

¹⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 159, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁶⁰ Ibid., 159-160.

¹⁶¹ Ibid., 160.

¹⁶² Ibid., vii-ix, 34.

¹⁶³ Ibid., vi, 20.

¹⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, K-5, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁶⁵ Interviews of VA staff by Commission on Care staff, April 2016.

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Facility Realignment

VA planning must closely examine the role of, and future for, individual facilities, in light of a transformative new delivery model. For more than a quarter century, VHA leaders have cited the need for medical center mission changes, realignments, disposal of unneeded buildings, and where indicated, hospital closures.¹⁶⁶ The critical importance of transforming VA health care delivery gives new urgency to providing tools to realign VHA's care-delivery infrastructure. The Commission recognizes that the SECVA does have authority to "consolidate, eliminate, abolish, or redistribute the functions of . . . [VA] facilities, and to carry out an administrative reorganization" of a field facility.¹⁶⁷ But that authority may generally not be unilaterally exercised.¹⁶⁸ In addition, despite VA's having established two previous commissions to address the need for facility realignment, leaders have had only limited success in achieving that objective. The exercise of SECVA's broad authority to reorganize is tempered by the prerogatives and fiscal authority held by Congress. Congress has rejected legislation that proposed a process to reassess the future of individual VA facilities,¹⁶⁹ reflecting concerns over veterans losing access to care and the potential of constituents losing employment. Such concerns can be addressed. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for sound planning; the exercise of objective, independent expertise; and a reliable mechanism for implementation. Congress can look to and adapt a proven model¹⁷⁰ – the military base realignment and closure (BRAC) process – to meet those objectives and achieve marked improvements in access to care.

Congress should enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed.¹⁷¹ This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to employ criteria set by the VHA Care System governing board (see Recommendation #9) to conduct locally-based analyses of capital assets, based on national process criteria. Information generated would be used to assist an independent commission, established under the

¹⁶⁶ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

¹⁶⁷ Authority to Reorganize Offices, 38 U.S.C. § 510.

¹⁶⁸ Authority to Reorganize Offices, 38 U.S.C. § 510(c). In instances where a reorganization would reduce employment by 15 percent or more at a facility, VA must provide Congress a detailed plan and justification, and must defer implementation for at least 45 days.

¹⁶⁹ Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999). Section 107 of House-passed H.R. 2116 would have established a mechanism for VA to cease providing hospital care at medical centers which were no longer providing high quality, efficient hospital care because of factors such as aging physical plant, functional obsolescence, and low utilization, and to redirect funds instead toward establishment of enhanced-service programs. In taking up H.R. 2116, the Senate did not adopt that provision, and it was not included in the Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999), accessed January 12, 2016, <https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm>

¹⁷⁰ Defense Base Closure and Realignment Commission, *Defense Base Closure and Realignment Act of 1990 (as amended through FY 05 Authorization Act)*, accessed June 23, 2016, <http://www.brac.gov/docs/BRAC05Legislation.pdf>.

¹⁷¹ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

legislation, in making recommendations regarding realignment and capital asset needs.¹⁷² The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan. The VHA Care System governing board would review, and adopt or make recommendations to revise, the independent commission's recommended realignment plan. The commission would then empower the VHA Care System governing board to implement the recommendations unless, within a specified timeframe, Congress disapproves the entire plan on an up or down vote. The Commission on Care envisions that after the completion of a realignment carried out under such proposed legislation and in the course of ongoing VHA transformation, the VHA Care System governing board would make all additional facility alignment decisions, to meet veterans' needs and to fully integrate with the strategic vision for the VHA Care System.

Repurposing and Divestiture of Unneeded Buildings and Land

Maintaining health care facilities to provide state-of-the-art care requires ongoing financial support. Bearing the additional cost of maintaining outdated, vacant, and unused buildings diminishes operating funds needed for patient care, and yields no benefit. Even taking unused buildings offline and placing them in *mothball status*, requires tens of millions of dollars in basic building maintenance.¹⁷³ If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.¹⁷⁴

Enhanced-use leasing authority has in the past provided VHA a viable tool that prevents the need for such unnecessary spending, while permitting development of vacant property for uses compatible with VHA's mission, and effective use of the proceeds, whether in cash or in kind.¹⁷⁵ This leasing mechanism has been put to particularly effective use in leveraging an asset that VHA can no longer use, but which has development potential, as consideration for an asset it may need, such as clinic space. But limiting enhanced-use leasing to a single use that may not be feasible in many locations precludes effective use of a valuable capital-alignment tool.

In many instances, however, the condition or remote location of VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant

¹⁷² The process should take into account the community health needs assessments (CHNA) that not-for-profit hospitals are required to carry out under current law, (Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat.119, sec. 9007(a) (2010)) and opportunities to engage community providers in collaborative partnerships. This provision requires tax-exempt hospitals to create a hospital community health needs assessment every three years. This hospital CHNA is developed alongside community stakeholders. The community health needs assessment requirements include: demographic assessment identifying the community the hospital serves; a community health needs assessment survey of perceived healthcare issues; quantitative analysis of actual health care issues; appraisal of current efforts to address the healthcare issues; and formulation of a 3-year plan under which the community comes together to address those remaining issues collectively.

¹⁷³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 49, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁷⁴ *Ibid.*, B-13.

¹⁷⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

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buildings for which there is no realistic prospect of their being repurposed, a streamlined divestiture process is needed.

Meeting Clinic Capacity and Other Infrastructure Needs

Developing a new delivery model and establishing a thorough realignment process may shrink VHA's future capital needs but will not eliminate them. As congressional budget rules have frustrated VHA efforts to lease needed clinic space, it is critical that VHA and Congress find models or remedies to establish new ambulatory care space and renew leases of existing clinics. Congress and VHA should work together to find the means to meet VHA's need for new clinic capacity. Given an impasse in congressional authorization of VA clinic leasing based on build-to-lease contracts, VA should explore the feasibility of restructuring those arrangements. VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, for which VA provides the builder with space needs rather than a complete design, would have the additional benefit of bringing projects on line much sooner. Absent an effective solution to meeting VA's ongoing need for clinic space, Congress must be willing, as it was in passing VACAA, to take extraordinary steps¹⁷⁶ to overcome a funding challenge, and, in this instance to waive, or suspend for at least 5 years, the operation of current congressional authorization and scorekeeping requirements governing major medical leases.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.¹⁷⁷ Notably, minor construction funds, available for "constructing, altering, extending, and improving"¹⁷⁸ any VA facility, are limited to \$10 million,¹⁷⁹ yet such projects may require substantially more given the age and condition of many VA buildings. Congress last lifted the threshold of what constitutes a major medical facility project – the amount above which a project requires specific authorization – more than a decade ago.¹⁸⁰ The Commission believes that with the tight controls a governing board would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

As VHA works more closely with community providers and participates in discussions regarding community health needs, it should be open to opportunities to discuss and potentially work toward joint efforts at meeting infrastructure needs.¹⁸¹

¹⁷⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 stat. 1754, sec. 803 (2014).

¹⁷⁷ VA Office of Inspector General, *Veterans Health Administration: Review of Minor Construction Program*, 8, accessed June 3, 2016, <http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf>.

¹⁷⁸ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 Div. J., Title II, Department of Veterans Affairs (2015).

¹⁷⁹ A major medical facility project is one involving a total expenditure of more than \$10 million. Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(a)(3)(A).

¹⁸⁰ Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006), raised the threshold as to what constitutes a major medical facility project from more than \$7 million to more than \$10 million.

¹⁸¹ One such public-private model, such as under discussion in Omaha, NE, where talks have centered on private donors' partially funding construction of a replacement medical center, necessarily poses challenges, but merits exploration and support. ("VA Exploring Public-Private Plan for New Facility," Lincoln Journal Star, accessed June 3, 2016, http://journalstar.com/news/state-and-regional/nebraska/va-exploring-public-private-plan-for-new-facility/article_6a90778e-6962-545f-a86a-3f27930bd84e.html.) Although Congress must ultimately provide apt facilities for VA care-delivery, the law has long authorized the SECVA to accept gifts or donations, for purposes of facility

Capital Asset Management

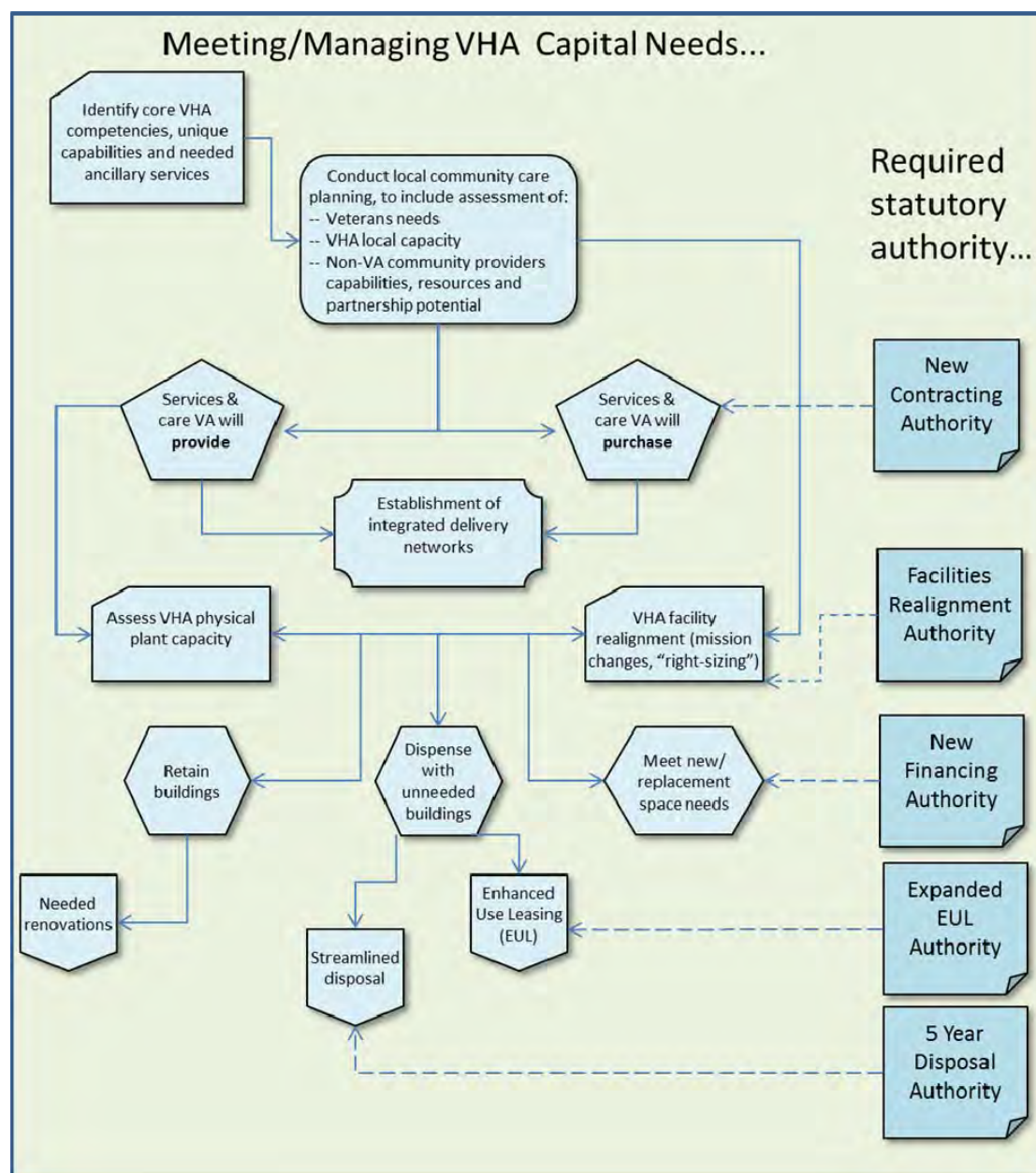
The Commission fully recognizes that VHA has much to do on its own to more effectively meet its capital asset needs. At the core, leaders must strengthen and streamline the capital asset programs' management and operation, to include better aligning the component elements; streamlining the leasing program, contracting, and investment decisions; managing and streamlining project delivery for construction and renovation; and adopting a facility (or building) life-cycle-model planning tool. These are all important elements of needed system transformation.

As depicted in Figure 3, meeting and managing VHA's capital-asset needs require an integrated approach that requires congressional support to tackle the multiple capital-asset challenges facing VHA. The Commission's recommendations for meeting and managing those interrelated capital-asset needs are set forth in the *Implementation* section following Figure 3.

construction. (Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(e)) Nevertheless, new legislative authority would almost assuredly be needed to permit development of public-private partnerships that provide new platforms for the construction of new or replacement medical facilities. For example, H.R. 5099 would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. To Establish a Pilot Program on Partnership Agreements to Construct New Facilities for the Department of Veterans Affairs, H.R. 5099, 114th Cong. (2016), <https://www.congress.gov/bill/114th-congress/house-bill/5099>.

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Figure 3. The Complicated Process of Meeting and Managing VHA's Capital-Needs

**Implementation****Legislative Changes**

- Provide VA new, more flexible authorities to realign facilities, meet capital-asset needs, and divest itself of unneeded buildings.
- Establishing a VHA capital asset realignment process that provides (notwithstanding any other law) for more effectively aligning VHA facilities with the objective of improving the access, quality, and cost-effectiveness of VA care, and provides for:

- Establishing an independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national capital asset realignment plan that would include recommendations to the VHA Care System governing board (see Recommendation #9) for systemwide facility realignment (to include changes in facility mission, facility downsizing, integration of facilities, and closures), with the rationale for each recommended change.
- The proposed plan would identify (a) the criteria used in developing realignment recommendations, (b) proposals for reinvestment and savings/cost avoidance resulting from the realignment, (c) the projected care improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA retrain and reemploys displaced employees.
- The VHA Care System governing board would be empowered to adopt or alter the proposed realignment plan, and to implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.
- Waive or suspend for at least 5 years current authorization and scorekeeping requirements governing major medical facility leases under 38 U.S.C. § 8104.
- Amend 38 U.S.C. § 8104 to lift the threshold of what constitutes a major medical facility project from \$10 million to \$50 million.
- Amend pertinent provisions of 38 U.S.C. § 8161, and what follows, to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.
- Provide the VHA Care System governing board authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements, (b) allowing VHA to retain the proceeds of any property sale, and (c) creating a streamlined process to address historic preservation considerations.

VA Administrative Changes

- None required.

Other Department and Agency Administrative Changes

- None required.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

Problem

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems and other health care providers; enables scheduling, billing, claims, and payment; and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹⁸²

VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, currently within VHA, there is no experienced senior health care IT leader focusing on the strategic health care IT needs of veterans and VHA staff.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Background

A fully functional electronic health record (EHR) can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.¹⁸³ Starting in the 1970s, VHA became a leader in the development of EHR technology with VistA and a computerized patient record system (CPRS).¹⁸⁴ Full implementation of the EHR, together with other reforms, helped improve the quality of care at VHA.¹⁸⁵ During the last decade, VHA has not been able to maintain an IT advantage.¹⁸⁶ Although in the past most VHA clinicians

¹⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁸³ "Does health information technology improve quality of care?" Robert Wood Johnson Foundation, accessed May 20, 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71333.

¹⁸⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 29-30, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

¹⁸⁵ Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours* (3rd ed., Berrett-Koehler Publishers, Inc., 2012). Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care* (November 2004), 828-836, accessed June 3, 2016, <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.450&rep=rep1&type=pdf>.

¹⁸⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed April 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

have had a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VHA's EHR at risk of becoming obsolete.¹⁸⁷ Many large U.S. health care systems that were early adopters of homegrown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.¹⁸⁸ DoD recently made the same choice.¹⁸⁹

To achieve the Commission's vision of a health care system that delivers quality, access, choice, and veteran well-being, VHA requires effective, robust, and modern information technology systems. A robust EHR system would allow veterans and clinical providers to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. It would be seamlessly interoperable with other systems including DoD, private-sector providers, and with other VA enterprise systems such as those in the Veterans Benefits Administration (VBA). It would support VHA clinical workflow, evidence-based practice, and patient safety. It would provide clinicians, patients, and administrators the data, analytic power, and user interfaces required to monitor the effectiveness of care and improve it over time. A robust IT system for VHA should include more than just the EHR, however, extending to all the systems and tools required to facilitate and automate business processes that support access and veterans' care. These capabilities include an effective scheduling system, telephone systems, mobile applications, telehealth, financial management systems, human resources systems, and other systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA requires exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.¹⁹⁰ Presently, VHA appears to lack a majority of these factors required for success.¹⁹¹

Analysis

Leadership and Staff

Prior to 2006, VHA had a chief health informatics officer responsible for the VHA electronic record system and for coordinating with VA on IT systems. The programmers in VHA worked closely with the clinicians who used the tool to create a system that met their needs.¹⁹² VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending; however, there was no specific budget line item for the electronic health

¹⁸⁷ Ibid., 29-30.

¹⁸⁸ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

¹⁸⁹ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

¹⁹⁰ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

¹⁹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 41, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

VA's IT budget was centralized in 2006, and the Office of Information and Technology (OIT) was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs became only one of the priorities that OIT has had to accommodate and VHA's priorities have not always prevailed.¹⁹³

To ensure that clinical needs and patient safety are a priority, many large health care systems, such as DoD, Cleveland Clinic, Geisinger, and Kaiser Permanente, have a medical CIO (i.e., CMIO) who manages and advocates for the clinical IT needs of the organization. A CMIO ensures that clinicians are involved in the selection of any IT systems they use to perform their job functions and provide patient care, including EHRs. Clinicians involved in the selection and deployment of an IT system are more likely to feel ownership of it and fully adopt its use. The CMIO usually reports to the health system's CEO or CMO, and working in concert with these individuals and the organization's CIO, makes sure that health information needs are prioritized and funded.¹⁹⁴

VA does not have staff with the necessary expertise to execute large-scale IT projects. Previous system implementations have failed because VA did not have individuals with adequate experience to effectively plan and manage system development and deployment. If VA had an adequate system and skilled staff to monitor and identify program and contracting problems affecting the progress of prior IT implementations, effective and timely decisions could have been made to either redirect or terminate VA IT projects that ultimately failed. To avoid repeating these previous IT implementation failures, VA needs to develop effective oversight systems and develop in-house staff with the expertise to oversee, fully support, manage, and execute complex integrated IT programs.¹⁹⁵

Given all of these critical needs, the Commission believes that it is essential for VHA to have a CIO with health care expertise and substantial experience, reporting to the chief of VHA Care System. The VHA CIO will be responsible for managing the complex implementation of a state-of-the-art comprehensive information system platform to support the new integrated VHA Care System, with the functionality, interoperability, and data management capabilities to support the delivery and coordination of high-quality health care for veterans. The CIO will need to work closely with clinical and operational leaders on the effective execution of the new system, and will also need to collaborate with the VA CIO to ensure the integration and coordination of the health care information system and the Veterans Benefit Administration system.

¹⁹³ Ibid., 10.

¹⁹⁴ "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, <https://www.acep.org/content.aspx?id=79744>.

¹⁹⁵ Department of Veterans Affairs Office of the Inspector General, *Review of the Awards and Administration of Task Orders Issues by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, accessed May 25, 2016, <http://www.va.gov/oig/52/reports/2009/VAOIG-09-01926-207.pdf>.

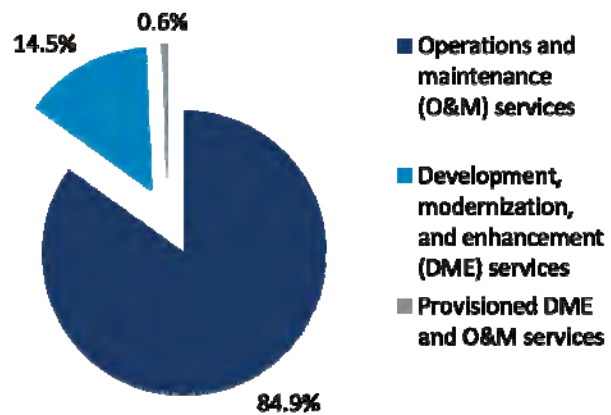
Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long-term development and important IT projects.¹⁹⁶ The budget process is disconnected from total lifecycle IT costs.¹⁹⁷ That disconnect has grown wider with a change in law¹⁹⁸ under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.¹⁹⁹ As the Congressional Research Service (CRS) testified,

*providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC).*²⁰⁰

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure 4),²⁰¹ meaning that essential upgrades like a new scheduling package and EHR modernization have not had the funding or focus required to succeed. Clinical users have become increasingly frustrated by the lack of any clear advances with VistA during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.²⁰²

Figure 4. VA IT Spending



In July 2015, DoD awarded a \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active-duty military members and retirees. Officials estimate that

¹⁹⁶ "Coming in 2016: Cloud Legislation," Aisha Chowdhry and Adam Mazmanian, accessed January 12, 2016, <https://fcw.com/articles/2015/12/22/cloud-bill-2016.aspx>.

¹⁹⁷ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

¹⁹⁸ Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).

¹⁹⁹ With the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 (December 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.

²⁰⁰ U.S. Congress, House of Representatives, Committee on Veterans Affairs, *Funding the U.S. Department of Veterans Affairs of the Future: Hearing before the Committee on Veterans Affairs U.S. House of Representatives*, 111th Congress, 1st Sess., April 29, 2009, 60, accessed June 3, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg49914/pdf/CHRG-111hhrg49914.pdf>.

²⁰¹ Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, <https://itdashboard.gov/drupal/summary/029>.

²⁰² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

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during its potential 18-year life, the contract could be worth just less than \$9 billion.²⁰³ The recent Senate appropriations bill for VA OIT allots \$63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).²⁰⁴ Assuming that VA's implementation of a new COTS EHR would be similar in size and scope to DoD's EHR implementation, VA would be short \$3.67 billion in funding for a new COTS EHR, given the current funding amount of \$63 million per year. VA will require a substantial increase in IT funding to support the successful implementation of a new comprehensive COTS EHR.

Robust Change Plan

Because VistA has been customized at each medical center, there are few standard data elements. The varied algorithms lead to a complex, heterogeneous mix of hardware and software that impedes system changes and new capabilities and raises operations and maintenance costs.²⁰⁵ Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited.²⁰⁶ VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform. The Commission recommends moving to a COTS program.

Whether VHA moves forward with the purchase of a COTS product, as recommended by the Commission, or continues attempting to modernize VistA, VHA must effectively manage the change process. At present, a lack of standard clinical documentation has made it harder to develop effective clinical decision-support systems and hinders EHR information exchange among VA Medical Centers (VAMC), between VA and non-VA facilities (including those of DoD), and between VA and individual veterans. Shared data must be well labeled in a way that the receiving system can identify and properly ingest such data. An electronic medical record can contain as many as 100,000 different data fields. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA, complicating information sharing, data aggregation, and analytics.²⁰⁷ VHA has not established comprehensive semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. Doing so is required to ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.²⁰⁸

The Office of the National Coordinator (ONC) for Health IT, under HHS, is responsible for advancing national connectivity and interoperability of health information technology. The

²⁰³ "Cerner wins \$4.3 billion DoD contract to overhaul electronic health records," Amy Brittain, *The Washington Post*, accessed May 25, 2016, https://www.washingtonpost.com/national/health-science/cerner-wins-dod-contract-to-overhaul-electronic-health-records/2015/07/29/7fbfccfa-35f5-11e5-b673-1df005a0fb28_story.html.

²⁰⁴ S. Rept. 114-237 – Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2017, accessed May 25, 2016, <https://www.congress.gov/congressional-report/114th-congress/senate-report/237/1>.

²⁰⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²⁰⁶ *Ibid.*, 41.

²⁰⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁰⁸ *Ibid.*, viii.

ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange, so information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.²⁰⁹ VA's intent to expand veteran care to more community providers through the creation of locally-integrated health care networks will mean that it is important for VHA to follow the ONC roadmap and standards. Following this roadmap includes using the continuity of care document to exchange data, which was established by ONC and is followed by community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and has committed VA to following the roadmap.²¹⁰

VHA does not yet have a robust, detailed strategy and roadmap for IT initiatives across VHA that integrates veteran access to scheduling via phone, telehealth, and mobile apps.²¹¹ National deployment of the VistA Scheduling Enhancement and the veteran mobile scheduling Veteran Appointment Request app, are initial steps to prepare for the implementation of new COTS electronic medical system with a scheduling package.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new COTS medical appointment scheduling system in August 2015.²¹² This system is a COTS scheduling solution that, when implemented, is expected to move VHA from primarily a face-to-face appointment model to a coherent, resource-based system with broad opportunities for improved services for VA stakeholders.²¹³ Deployment is awaiting the final decision on whether VHA will continue with VistA or purchase a full COTS product.

COTS Solution

The current VistA/computerized patient records systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose barriers to modernizing the respective systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts.²¹⁴ Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different versions of VistA across the country.²¹⁵

²⁰⁹ "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, <https://www.healthit.gov/policy-researchers-implementers/interoperability>.

²¹⁰ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²¹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹² "\$623M Medical Appointment Scheduling System (MASS) Contract," G2Xchange, accessed May 3, 2016, <https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract>.

²¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 40, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹⁴ *Ibid.*, vi.

²¹⁵ *Ibid.*, vi.

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VHA relies on a VistA scheduling package to provide veterans with access to health care. The system is antiquated, highly inefficient, does not optimally support processes or allow for efficient scheduling of appointments. A report on scheduling published by the Northern Virginia Technology Council (NVTC) in October 2014, showed that VA's exam-scheduling processes are not enabled by state-of-the-art technologies or consistently applied standard operating procedures.²¹⁶ To improve this situation, VHA has developed, and is in the process of a national roll out of, VistA scheduling enhancements, which provides an improved user interface (i.e., graphic user interface or GUI). Although the new GUI will help veterans gain access to care by implementing better scheduling procedures, it does not address the need that managers, planners, and administrators have for accurate and timely data on clinic use.²¹⁷ For instance, VHA's new health care operations dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.²¹⁸ However when questioned about this data, VHA notes that it is not correct.²¹⁹ The underlying VistA scheduling software does not allow accurate representation of clinician time toward each clinic stop. As a result, whether data is presented in a dashboard or a new GUI tool, as long as the underlying data cannot be captured accurately, then VHA will not have the information it needs to effectively manage the supply of clinic slots.²²⁰

VA's financial management information technology system is woefully outdated and VA has previously wasted approximately \$500 million in two failed attempts to replace it. Given VA's lack of an integrated finance and logistics IT system, VA has no method to perform commitment accounting.²²¹ VA's current financial management system does not support streamlining and automation of VA's revenue cycle.²²²

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.²²³ VA's information technology systems limitations often demand manual processes to support community care that can reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. Relying on manual processes slows collections and payment activities and introduces errors and waste into the process.²²⁴ Barriers to automation are multifactorial,

²¹⁶ Ibid., 39-40.

²¹⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²¹⁸ Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²¹⁹ Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²²⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²²¹ Jan R. Frye, *Letter to Secretary McDonald, March 19, 2015*, accessed May 17, 2016, http://extras.mnginteractive.com/live/media/site36/2015/0522/20150522_025126_WhistleblowerMemo.pdf.

²²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 24, accessed May 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

²²³ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 42, accessed March 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

including confusing eligibility rules governing which veterans may receive care outside VHA and for what conditions, in what circumstances, and which services may be billed to third-party insurers.²²⁵ In addition, there are multiple authorities for purchasing community care—all with different business rules²²⁶ and reimbursement rates, as well as antiquated financial management information systems that are not standardized to private-sector processes. All of these impediments are exacerbated by workers throughout the revenue cycle who are poorly compensated and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;²²⁷ thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.²²⁸

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.²²⁹ DoD recently made the same choice, deciding to replace its homegrown EHR with a COTS product to take advantage of private-sector innovation and have an EHR that communicates with private-sector systems. For a system in which 60 to 70 percent of military health care takes place outside the DoD,²³⁰ this was an important business consideration that is also consistent with VHA's long term direction. Very large IT programs with purpose-built systems and labor-driven business models are shifting rapidly toward more open source, COTS systems. Large proprietary IT solutions are increasingly being replaced by less risky, agile, and open-source solutions or IT as-a-service models, and getting away from client-server models.²³¹

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and other non-VHA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially substantial implications for veterans and VHA. Incomplete records introduce unnecessary clinical risk, complicate the transition from

²²⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I (Business Processes)*, 19-20, accessed April 26, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁶ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁷ Healthcare Talent Management, Veterans Health Administration, email to Commission on Care, April 11, 2016. Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans*, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

²²⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I, Business Processes*, I3-I4, accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

²³⁰ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

²³¹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

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DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.²³²

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.²³³ They have deployed the Joint Legacy Viewer (JLV), which provides a patient-centric, integrated view of a patient's health data from VA, DoD, and community health partners on one screen. It has been available at all VA medical centers since October 2014 and currently has more than 70,000 users.²³⁴ The JLV is a positive step in supporting coordination of care among VA, DoD, and community partners, but it only allows for providers to view veterans'/service members' medical records and does not yet allow for the other agencies' medical records to be updated by providers.²³⁵

VA's next evolution in interoperability with DoD and community partners is the deployment of their Enterprise Health Management Platform (eHMP). eHMP is intended to provide VA streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable, and secure interface that is easy to use. It is reported to deliver a modern, web-based user interface and supporting infrastructure and is intended to replace the Computerized Patient Record System (CPRS) as VA's primary point-of-care application. The national rollout of eHMP is expected to be completed by December 2017.²³⁶

VHA does not have everything that is needed in an IT system to manage the business and clinical aspects of care in the community and support the overall veteran experience in an expanded community network. To address these gaps and provide health care well into the future, VA intends to develop in house a comprehensive and interoperable digital health platform (DHP). The DHP is intended to seamlessly integrate all of VHA's core processes, including scheduling, supply chain management, billing, and claims. Through consolidation of more than 40 contact center systems and more than 130 versions of the VistA EHR and clinical procurement/inventory systems, the DHP is designed to enable VHA's operation as a holistic, platform business and greatly reduce the cost of system maintenance across the IT enterprise.²³⁷

Because there is no unique patient identifier, problems exist with "1) accessing and integrating information from different providers and provider computer systems, 2) aggregating and providing a lifelong view of a patient's information, and 3) supporting population-based research and development."²³⁸ To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient

²³² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²³³ "Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts," U.S. Government Accountability Office, accessed April 1, 2016, <http://www.gao.gov/products/GAO-16-184T>.

²³⁴ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-35, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²³⁶ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁷ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²³⁸ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf>.

identifier. This practice is currently not used.²³⁹ Each health care system uses a unique patient identifier number, but it is specific to that system.²⁴⁰ VA uses patients' social security numbers as unique identifiers; whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to match patient identities between record systems. Studies have shown that patient identification error rates range from 7-20 percent.²⁴¹ For VA to accurately identify patients and their records, a unique national patient identifier is essential.

The security of electronic records is an ongoing concern. One in three Americans had health care records breached in 2015.²⁴² Recent hacks of U.S. hospital health care systems through the use of ransomware, viruses that hold systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.²⁴³ VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in its annual FISMA audit reports.²⁴⁴ Although VA has recently made some progress in developing policies and procedures to address current security gaps, OIG's FY 2015 audit concluded that information security is still a *material weakness* for VA and that VA must take comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems.²⁴⁵ For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.²⁴⁶ Interoperability increases the risk to veterans' health records.²⁴⁷ Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;²⁴⁸ however, security protocols also cannot impede health information exchange with VA community providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which

²³⁹ "Interoperability 2015: Current State and Next Steps", Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁰ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPVU-508.pdf>.

²⁴¹ "The Right Fit: How We Solve the Puzzle of Interoperability," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/telemedicine/the-right-fit-how-we-solve-the-puzzle-of-interoperability>.

²⁴² "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

²⁴³ "Virus Infects Medstar Health System's Computers, Forcing an Online Shutdown," John Woodrow Cox, Karen Turner and Matt Zapotosky, accessed March 28, 2016, https://www.washingtonpost.com/local/virus-infects-medstar-health-systems-computers-hospital-officials-say/2016/03/28/480f7d66-f515-11e5-a3ce-f06b5ba21f33_story.html?hpid=hp_local-news_medstar-health-virus-345pm_percent3Ahomepage_percent2Fstory.

²⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁴⁵ Department of Veterans Affairs, Office of the Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2015*, accessed May 25, 2016, <http://www.va.gov/oig/pubs/VAOIG-15-01957-100.pdf>.

²⁴⁶ "Interoperability 2015: Current State and Next Steps; Market Immaturity Highlights Opportunity," Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁷ Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.

²⁴⁸ "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 17, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

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are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.²⁴⁹

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VHA/community care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged in these networks because, due to lack of awareness, only 3 percent of veterans have opted in to allow VA to share their health information.²⁵⁰ The standard industry policy is to have patients opt out of having their health data shared with their other health care providers. VA is prohibited from taking this approach because statutory language in 38 U.S.C. § 7332 prohibits VA from disclosing information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia, except when required in emergencies, without written authorized consent from the patient.²⁵¹

In response to this limitation, VA approved and submitted Legislative Proposal VHA-10 (10P-07), Authority for the Department of Veterans Affairs (VA) to Release Patient Information under 38 U.S.C. § 7332 to Health Care Providers for Treatment of Shared Patients in 2013. The proposal allows veterans to opt out of sharing their data with VA community providers instead of having to opt in. The proposal was approved by OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee staff in April 2015 on this legislative proposal. A House Bill was introduced, but it limited the opt-out option to the *Choice Program*. VA's Office of Congressional and Legislative Affairs responded back to Congress that the bill should be expanded to include all external purchased care options (i.e., community providers) thus directly supporting more veterans.²⁵²

Collaboration between VA OIT and VHA is paramount to transforming VHA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring that the strategic and operational IT needs of VHA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments, including VHA.²⁵³ An account manager is neither senior enough, nor has the level of expertise and experience, to manage the complexity of the VHA IT system. VHA's extensive IT needs require a VHA CIO with authority over the health IT budget and the execution of the health IT strategy. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the CVCS and the VA CIO to define the health IT strategy and key IT acquisitions/projects and ensure that health IT funding is aligned and committed to the execution of VHA's health IT

²⁴⁹ Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.

²⁵⁰ Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015

²⁵¹ 38 U.S.C. § 7332 Subchapter III - Protection of Patient Rights Sec. 7332 - Confidentiality of certain medical records.

²⁵² Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.

²⁵³ "OI&T Enterprise Strategy: Putting Veterans First," LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

strategy. Rolling out a new system takes multiple years, and VA must commit to funding system deployments to completion.

The modernization of VHA's IT infrastructure requires a substantial increase in and reallocation of VA's IT budget to implement it. The budget process for VA health care IT funding should be the same as the process for VHA medical care funding. That shift can be accomplished by establishing a separate line item for *health* IT within VA's IT appropriation, and providing for advanced appropriations for that account. In addition, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act of April 2016, would create a \$3.1 billion revolving fund for upgrading outdated federal IT systems.²⁵⁴

The Commission strongly recommends that VA purchase a comprehensive COTS health IT platform, and implement all information systems with minimal customization. VHA leadership is in the process of assessing whether VistA is the best solution to support veterans' future health care needs or whether a new EHR, such as a COTS product or open-source EHR, should be used.²⁵⁵ The decision to choose a COTS product would be consistent the approach adopted by DoD and by other large health systems that have moved away from homegrown solutions to commercial and open-source products. It would allow VHA to focus energy on excellent patient care as a core competency and shift the IT development and maintenance risk of software products to external vendors with more expertise in this area.²⁵⁶ It is also likely to accelerate interoperability as vendors continue to offer IT solutions that meet meaningful use standards and the roadmap published by ONC.

A COTS product must be able to execute key functionalities required by VHA. These requirements include one standard version of an EHR across all VHA sites of care; interoperability within VA, such as with Veterans Benefit Administration (VBA), and between VHA and DoD, and community providers; robust security; and the ability to accommodate a national unique patient identifier. This system must also be a robust clinical management tool that supports VHA clinical workflow and has a customizable interface for clinical users, allows for evidence-based clinical order sets and patient safety features like automated medication reconciliation, has robust analytic capability for both clinical and administrative functions, and enables automated abstraction and reporting of performance measures.

The system must also seamlessly support administrative functions like scheduling, patient intake, eligibility determination, referrals, and patient out-of-pocket expense determination. The system must enable effective business operations in billing coding, automated claims processing, and all aspects of supply chain management. This COTS purchase should include a scheduling package. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities.

²⁵⁴ "Two IT Modernization Bills Could See Movement in Congress," Aisha Chowdhry, accessed April 28, 2016, <https://washingtontechnology.com/articles/2016/04/22/it-bills-congress.aspx>.

⁷³ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²⁵⁶ "DoD awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

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Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.²⁵⁷

For VHA to transition to a COTS product, the new VHA CIO must develop and implement a strategy that will allow the current nonstandard data to effectively roll into a new system, engage clinical-end users and internal experts in the procurement and transition process, ensure effective cybersecurity, and limit spending on the current systems to fund only critical changes required for continued operations. Finally, this plan should be coordinated with ONC and DoD.

Implementation

Legislative Changes

- Provide a specific appropriation to fully fund the complete development and deployment of the comprehensive COTS electronic health platform, recognizing this will require significant resources above the current annual appropriation and funding to support VHA's IT transformation; including funds that ensure appropriate training of all staff, recognize loss of staff productivity during implementation, and provide proper maintenance and upgrades of VA IT infrastructure in preparation for new and successor technologies.
- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account, consistent with the overall VHA IT strategy.
- Amend section 38 U.S.C. §7332, to authorize VA to share protected health information under the same rules as all other HIPAA protected information.

VA Administrative Changes

- Hire a CIO for the VHA IT transformation. The CIO should report to the CVCS, with secondary reporting responsibility to VA CIO.
- Establish a transformation strategy that addresses all of the following needs (as directed by the VHA CIO):
 - standardizes data elements in the current IT systems through the use of standard nomenclatures, terminologies and code sets in order to promote the transition to a COTS EHR and to support interoperability²⁵⁸
 - develops a robust cybersecurity plan for VHA IT infrastructure, in coordination with VA CIO and Chief Information Security Office, which addresses both current systems and defines
 - the requirements for new systems

²⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 46, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁵⁸ Ibid., 55.

- collaborates with the Office of the National Coordinator for Health IT on national interoperability standards and implementation
- limits any continued VistA development and associated spending to only those upgrades required to keep VistA functioning until a new system is in place
- Plan and implement procurement of a comprehensive COTS electronic health platform that executes all of the following requirements:
 - establishes one logical version of an electronic health record platform in VHA²⁵⁹
 - standardizes evidenced-based, best practice clinical order sets across VHA
 - incorporates effective analytic capabilities to drive health and business outcomes and offers the ability to interface with other tools for data management and presentation²⁶⁰
 - modernizes appointment scheduling so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans²⁶¹
 - accomplishes a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, third party collections, and other core VHA business processes, including the following specific capabilities: integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction²⁶²
 - supports the business processes required to implement integrated community care networks, including eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service
 - promotes full interoperability with IT systems across VA (including VBA and National Cemetery Administration) and between VA and DoD
 - supports the development of full interoperability with integrated community care network facilities and providers

²⁵⁹ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²⁶⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, viii, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁶¹ The Independent Budget, *The Independent Budget—Veterans Agenda for the 114th Congress: Policy Recommendations for Congress and the Administration*, accessed May 17, 2016, http://www.independentbudget.org/2016/IB_FY16.pdf.

²⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness that are the same as the private sector
- includes functionality to use a national unique patient identifier
- integrates supply chain and financial systems with the electronic health records to provide accurate operational data²⁶³
- Streamline its current IT procurement processes so that IT procurement is expeditious, including lengthier contract vehicles with more options, the use of indefinite delivery indefinite quantity vehicles, blanket purchase agreements, time and material contracts, and flexible contract structures to allow for the onboarding of emerging technologies in a competitive fashion.
- Increase health IT expertise within VHA.

Other Department and Agency Administrative Changes

- CMS and federal health care providers should collaborate to develop a national unique patient identifier standard. CMS should require health care providers to use these identifiers as a condition of participation in Medicare and HHS should require federally qualified health centers to use them as a condition of participation. The President should require all federal health care providers to adopt the standard.

²⁶³ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.²⁶⁴

Background

Health systems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize cost savings, while maintaining quality services.²⁶⁵ This effort includes examining the supply chain for ways to save money.²⁶⁶

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

²⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁶⁵ Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

²⁶⁶ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "5 Ways Supply Chain Can Reduce Rising Health Care Costs," Jasmine Pennie, accessed April 28, 2016, <http://hitconsultant.net/2013/05/13/5-ways-supply-chain-can-reduce-rising-health-care-costs/>.

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Price competition achieved through technology and aggressive management of supply chain efficiencies by retailers such as Walmart and Amazon are held up as just the kind of disruption that health care requires.²⁶⁷ Health care organizations as diverse as Kaiser Permanente, Cleveland Clinic, Stanford Medicine, and Johns Hopkins Health System have taken on the challenge of transforming their supply chains, realizing savings of as much as hundreds of millions of dollars.²⁶⁸ VHA, which in FY 2014 spent approximately \$3.4 billion on clinical supplies, medical devices, and prosthetic appliances, has an opportunity to realize similar savings.²⁶⁹

Opportunities for efficiency in the supply chain include reducing pricing for purchases and lowering operating costs of procurement processes. To achieve price savings, organizations must have detailed information on what products they use, understand and reduce variability in the products purchased, and aggressively negotiate pricing, usually by consolidating purchases to a small number of preferred vendors who are willing to offer volume discounts and improve service delivery. On the operations side, cost savings are achieved by managing inventory lifecycle and restocking processes; order management; and the logistics of shipping, receiving, and transportation to drive down costs and lower waste and breakage. In health care, it also pays to ensure that clinical staff, both nurses and doctors, are treating patients rather than conducting inventory checks or ordering and collecting supplies.²⁷⁰ To be successful in managing the supply chain in health care, a partnership with clinical staff is key. Variability in device and supply purchases can be driven by clinician preferences and thus, to reduce variability, clinicians must be engaged in analyzing product options and examining data on product effectiveness to determine what products to use with patients.²⁷¹

VHA has a successful internal model of aggressive supply chain management that can serve as a model for improving the management of medical, surgical and other supplies: the VHA Pharmacy Benefits Management Service (PBM). PBM has taken a systems approach to

²⁶⁷ John Agwunobi and Paul London, "Removing Costs from the Health Care Supply Chain: Lessons from Mass Retail," *Health Affairs*, 28, no 5, (2009): 1336-1342, accessed April 26, 2016, <http://content.healthaffairs.org/content/28/5/1336>.

²⁶⁸ "In Age of Mergers, Hospitals Get Strategic with Medical Supply Purchasing," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/age-mergers-hospitals-get-strategic-medical-supply-purchasing>. "Supply Chain Management," Cleveland Clinic, accessed April 27, 2016, <http://my.clevelandclinic.org/services/supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

²⁶⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 47, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁰ "EY Provider Post: Choosing Your Innovation Pathway," EY, accessed April 26, 2016, <http://www.ey.com/US/en/Industries/United-States-sectors/Health-Care/Provider-Post--Choosing-your-innovation-pathway>.

²⁷¹ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "Strategic Supply Chain Management," Lee Ann Jarrow, accessed April 28, 2016, <http://www.hhnmag.com/articles/4522-strategic-supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

managing pharmaceutical supplies, logistics, and prescribing.²⁷² PBM has largely solved the internal contracting deficiencies in VA by consolidating its activities under just two contracting organizations that oversee all national-level contracts for pharmaceuticals. PBM also applies effective mechanisms to drive standardization of supplies through a national formulary, clinical guidelines for prescribers and utilization review, and feedback to help clinicians identify outlier prescribing practices.²⁷³ Vital to the success of this program is the involvement of clinicians and pharmacists in a vertically integrated model of engagement and decision making through facility-level, Veterans Integrated Service Network (VISN)-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.²⁷⁴ PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical leaders across the system are helping drive PBM policy and practices.²⁷⁵ As a result, 90 percent of purchases are acquired through pharmaceutical prime vendor contracts.²⁷⁶

PBM, taking advantage of standardized industry nomenclature and bar codes for pharmaceuticals, has implemented automated dispensing, distribution, and ordering processes, including VA's Consolidated Mail Outpatient Pharmacy (CMOP).²⁷⁷ The use of CMOP, a system of seven highly automated pharmacies that process more than 460,000 prescriptions every work day, results in exceptional accuracy and lower processing costs than would result if filling prescriptions at each VAMC.²⁷⁸ Eighty percent of prescriptions in VHA are filled through CMOP,²⁷⁹ which has been recognized for the last 6 years as the best or one of the best mail order pharmacies in the country meeting or exceeding customer satisfaction scores of health care systems like Kaiser Permanente and on-line pharmacies like Express Scripts and Walgreens Online Pharmacy.²⁸⁰ Customer service, veteran satisfaction, and patient safety delivered through team-based care are a hallmark of the mission of PBM,²⁸¹ and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

²⁷² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 19, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷³ *Ibid.*, 20.

²⁷⁴ VHA Formulary Management Process, VHA Handbook 1108.08 (2009).

²⁷⁵ Clinical Pharmacy Services, VHA Handbook 1108.11, 28-30 (2015). The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 32-34, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁷ *Ibid.*

²⁷⁸ "VA Mail Order Pharmacy," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp.

²⁷⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸⁰ "U.S. Pharmacy Study – Mail Order (2015)," J.D. Power, accessed April 29, 2016, <http://www.jdpower.com/ratings/study/U.S.-Pharmacy-Study-Mail-Order/631ENG2>.

²⁸¹ "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, <http://www.pbm.va.gov/PBM/index.asp>.

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Analysis

VHA's supply chain for clinical supplies, medical devices, and related services is inadequate compared to the agency's pharmacy organization or to best practices in leading hospital systems.

*Its contracting processes are bureaucratic and slow, which can delay veterans access to care. Purchasing processes are cumbersome which has driven VHA staff to work arounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given a lack of data which likely leads to significant avoidable expense for VA.*²⁸²

Leadership and Organizational Structure and Function

Best-in-class supply chain organizations typically have a single group responsible for the strategy, sourcing, procurement, and logistics of clinical supplies and medical devices. The organization is typically led by an executive-level leader, such as a chief supply chain officer (CSCO), and personnel are aligned along product categories to develop and use deep expertise in the products and suppliers they manage.²⁸³ In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.²⁸⁴ Four contracting entities are located within VA central office but report to two different management offices within VA's office of acquisition, logistics, and construction (OALC).²⁸⁵ Procurement personnel within VHA's regional contracting and VISN offices report to VHA's national office of procurement. In contrast, facility-based and VISN logistics personnel report to their local VAMC or VISN director and not to the national VHA logistics office.²⁸⁶ To further complicate the management picture, clinical supplies are managed by the logistics organization, yet medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)²⁸⁷ (see Figure 5). In most health care organizations, the supply chain chief operating officer and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.²⁸⁸ This is not the case in VA. Senior leaders in VA's and VHA's supply chain organizations and field-based supply chain personnel indicate current organizational structure is too complex and should be simplified.

*National supply chain leaders expressed lack of clarity regarding the scope of responsibilities of the entities for which they are responsible, which has led to some tension and what one leader described as a 'turf war.' Others described a vacuum of ownership and accountability, and lack of clarity on roles and responsibilities.*²⁸⁹

²⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, v, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸³ Ibid., 57-58.

²⁸⁴ Ibid., ix.

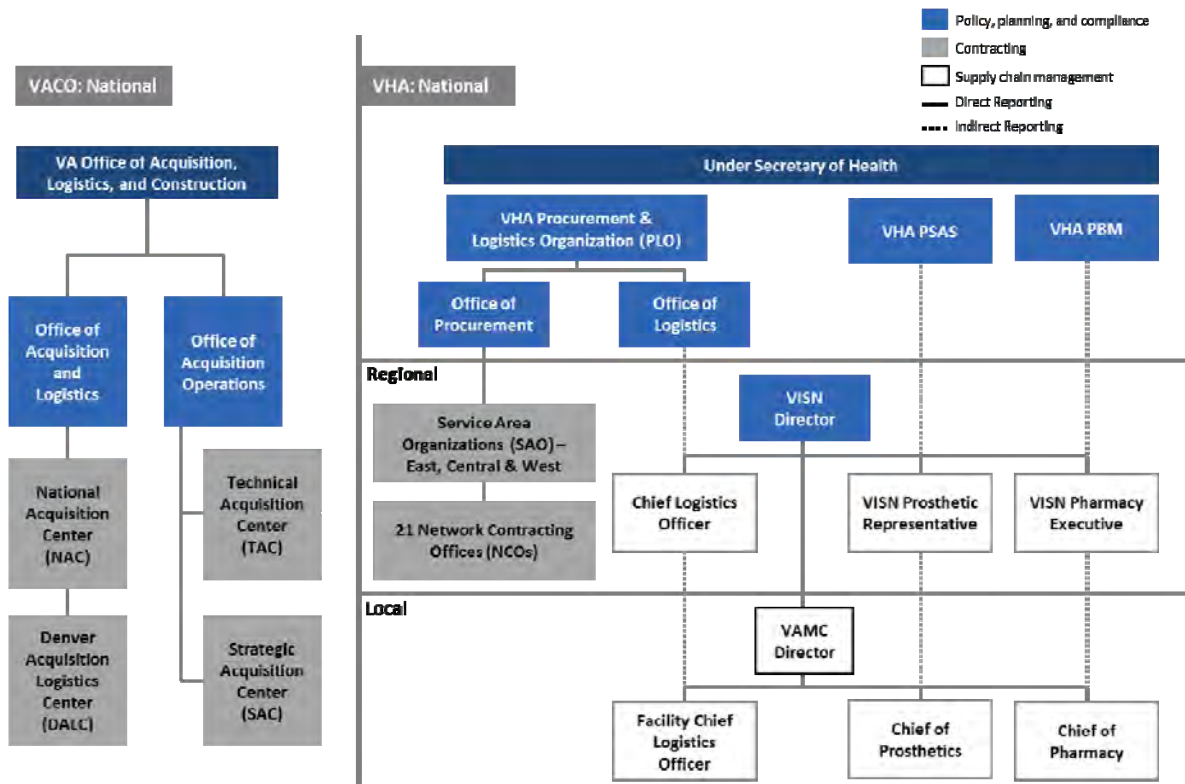
²⁸⁵ Ibid., 96-97.

²⁸⁶ Ibid., 47-50.

²⁸⁷ Ibid., 58.

²⁸⁸ Ibid.

²⁸⁹ Ibid., 55.

Figure 5. Organizations Comprising VA's Supply Chain²⁹⁰

Notes: Some VISNs may have different reporting relationships with facility prosthetics staff.

The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Frontline staff members indicate the time it takes to procure simple items through contracting (1 to 3 months) is problematic. For example, heart valve surgery may be delayed because some heart valves cost more than the micro-purchase threshold (\$3,000), thus the purchase must be made through the contracting process.²⁹¹ Medical center staff consistently expressed concern that VHA procurement offices are not responsive to the needs of a health care organization and do not communicate effectively with them,²⁹² findings borne out by low customer satisfaction scores given to these organizations.²⁹³

There is great overlap and redundancy in procurement and logistics functions in VA and VHA and the reporting structures are not aligned to ensure that the needs of veteran patients and their clinical providers are met. In an environment with limited sharing of best practices and a lack of transparent, open communications, the current complicated reporting structures impede customer-service quality and effectiveness. The original intent behind the current structure was to consolidate and strengthen purchasing power through the establishment of national contracts; however implementation of the vision has been poor and the result has been a

²⁹⁰ Ibid., 49.

²⁹¹ Ibid., 67.

²⁹² Ibid., 68.

²⁹³ Ibid., 69.

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complicated, bureaucratic system filled with redundancies.²⁹⁴ These broken processes serve as a precursor for catastrophic systems failures.²⁹⁵

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority but the rest of the supply chain needs to be addressed by the CSCO in a staged approach. The VERC or other experts in business process engineering must be engaged to create a vertically aligned organizational structure with clear delegated responsibilities at each level of the organization to create an efficient and responsive procurements and logistics process which the VHA CSCO would lead.

Clinical Engagement and Value Analysis

In contrast to pharmaceuticals, usage of clinical supplies and medical devices is not strictly monitored or managed in VA. In general, physicians and nurses can choose whichever products they believe are best for patients and the supply chain organization's role is to make those items available.²⁹⁶

VHA does not have a means to determine what supplies should be standardized or a feedback loop administrators and staff use to assess whether standards were being used when they did exist.²⁹⁷ As a result, limited product standardization has been achieved across VHA, despite VHA establishment of national standardization user groups in 2001 responsible for identifying items for standardization based on national procurement data.²⁹⁸ To date, national product standardization has been achieved in only a limited number of categories.²⁹⁹ Since 2011,

VHA required that medical centers establish Clinical Product Review Committees (CPRCs) to: (i) review and approve the use of new clinical items and reusable medical equipment (RME) at each medical center; (ii) maintain a list of approved expendable clinical supplies and RME by establishing and maintaining a Medical/Surgical Supply Formulary; and (iii) ensure compliance with nationally standardized contracts and blanket purchase agreements. In all sites visited, CPRCs exist and meet regularly but reviews were generally formalities.³⁰⁰

²⁹⁴ Ibid., 47-50.

²⁹⁵ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

²⁹⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 54, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁹⁷ Ibid., xii.

²⁹⁸ VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.

²⁹⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 81, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁰ Ibid., 82.

Under this 2011 policy, the establishment of VISN oversight committees was also required to provide accountability and feedback to the local committees, but these committees were apparently never established.³⁰¹

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), is making progress on clinician alignment to accomplish value-based purchasing decisions for medical and surgical supplies. VERC has recently rolled out a national clinical product review committee (CPRC-E) e-portal to better organize this function. This portal provides a central system and standard processes for all new product requests and approvals to inform the procurement processes.³⁰²

In the area of medical and surgical supplies, clinician preference can drive variability in procurement and utilization. As has been done in VHA for pharmaceutical prescribing, a similar system to engage and align clinicians must be undertaken for medical devices and surgical supplies. VERC has started this process, but requires further funding and leadership support to fully implement a clinician-driven sourcing process. Current and future leaders of VA and VHA must ensure that VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from a VHA CSCO.

Information Technology, Data Standards, and Analytics

Information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing impede VHA's ability to effectively manage its supply chain.³⁰³ VHA needs greater "end-to-end visibility into the operational and financial performance of their supply chain" and more effective means to accomplish supply chain budgeting, forecasting, inventory management and automation of at least some key supply chain functions.³⁰⁴

*VA lacks visibility into supplies and devices spending at the level of granularity usually seen in the private sector. For example, in the private sector, it is typically possible to measure clinical supply spend and utilization at the service, patient, or physician level. However, this is not possible in VHA because it does not capture such data. Therefore, supplies spend per case can only be calculated in aggregate, which is relatively meaningless and does not allow for fair comparison across hospitals, services, or physicians. This inhibits VA's ability to manage utilization and to understand fully the impact of product standardization efforts.*³⁰⁵

VERC is working to reduce the more than 130 versions of VistA in place across the country so that the same data sets can be tracked and reported.³⁰⁶ Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names

³⁰¹ Ibid., 54.

³⁰² Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.

³⁰³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁴ Ibid.

³⁰⁵ Ibid., 60.

³⁰⁶ Ibid.

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and provide data integration across all of VHA. Point of Use Solution, a commercial off the shelf supply management software product, has been purchased to achieve better inventory and demand management control and has been deployed to 32 percent of facilities, as of April 2016.³⁰⁷

True sustainment of a clinician driven process cannot be achieved with fragmented information systems that do not communicate. Leaders at all levels of the organization are not able to effectively identify and manage procurement requirements or provide effective feedback to clinicians on utilization. Similarly, automated inventory control, ordering, billing, and payment cannot occur without a seamless information technology infrastructure. With a current IT system in which fiscal, supply chain, and clinical informatics systems do not interface, the hopes of moving to automated processes for supply ordering, equipment life cycle management, and vendor communications cannot be realized. A plan for the transformation of supply chain management, developed by a VHA CSCO with support from VERC, must be fully integrated with planning and procurement within OI&T and fully financed to accomplish these important goals.

Policy and Procedures

Ninety-eight percent of all clinical supplies are acquired using purchase cards³⁰⁸ and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.³⁰⁹ This is not a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete,³¹⁰ yet use of purchase cards is inefficient as this mechanism does not take advantage of economies of scale and potential cost savings an organization the size of VHA can achieve through price negotiations and strategic sourcing.³¹¹ It can also be contrary to law, as use of purchase cards often necessitates orders be split to remain under the \$3,000 purchase card limit.³¹² An analysis of purchase records showed that 38 percent of supply orders were made through standing vendor contracts which is in stark contrast to the private sector benchmark of aiming to complete 80-90 percent of supply purchases from master contracts with negotiated price discounts.³¹³ Indeed, the private sector trend in health care has been for hospitals and health care systems to form alliances in “group purchasing organizations” to achieve the scale that VHA naturally enjoys.³¹⁴ Weaknesses in logistic management have been recognized in VHA for some time and still remain.³¹⁵ For instance, a review of logistics business

³⁰⁷ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³⁰⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁹ Ibid., xii.

³¹⁰ Ibid., x.

³¹¹ U.S. Government Accountability Office, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, accessed April 28, 2016, <http://www.gao.gov/assets/650/648644.pdf>.

³¹² U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System*, accessed April 28, 2016, <http://www.va.gov/oig/pubs/VAOIG-11-00826-261.pdf>.

³¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³¹⁴ Bob Kehoe, “Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness,” *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

³¹⁵ U.S. Government Accountability Office, *Veteran’s Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, accessed April 28, 2016, <http://www.gao.gov/assets/660/653886.pdf>.

practices at 17 VHA medical facilities in 2014 showed that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of noncompliance ranged from 53 to 88 percent, depending on the business metrics examined.³¹⁶

VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the governmentwide regulations to promote simplified purchasing procedures.³¹⁷

VERC initiatives to improve VHA supply chain are intended to standardize business processes and address the great price variations for the purchasing of medical and surgical supplies. A national medical surgical prime vendor (MSPV) contract has been established. This development has several advantages to include (a) increased ability to leverage pricing negotiations; (b) standardized pricing; (c) elimination of redundant contract development, bidding, and selection; and (d) future ability to integrate with CPRC E-Portal.³¹⁸ VA has established a goal for 85 percent of all orders in FY 2016 be made under the prime vendor contract and has made 1,100 contracting officers available to meet demand against the contract.³¹⁹ As of April 2016, an estimated \$24.4 million in supply chain costs had already been avoided since January.³²⁰

The establishment of a new MSVP contract in April 2016, the assignment of 1,100 staff to support its use, and the expectation communicated to the field that 85 percent of all purchases be made from the contract are important steps in the right direction. For efficient ordering processes to take hold and be sustained across VHA, all of the policies and procedures from the bedside (or surgical suite) to the head contracting office must be reworked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the organization. Each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the VA Acquisition Regulation (VAAR) is just one small piece of such a transformational change. The VERC or others with appropriate experience in aligning business processes within government should be assigned responsibility to finish developing and implementing plans for such a transformation under the direction of a VHA CSCO.

Contracting

Analysis of the *Independent Assessment Report* confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21 to 39 days from the date of initial submission to

³¹⁶ U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.

³¹⁷ Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.

³¹⁸ Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.

³¹⁹ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³²⁰ Ibid.

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receive the first response from contracting requesting, for example, additional information or paperwork.³²¹ This problem appears to be a widespread.

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes to order equipment valued at less than \$3,000, for example, scalars for dentistry, can be confusing and lengthy, leading to shortages in equipment and delays in clinic as equipment is located. Delays in sterile processing were also indicated by providers as an issue pertaining to equipment availability.³²²

Communication with contracting is another substantial challenge within VHA. In surveys that assessed the effectiveness of VA's contracting organization, VHA employees' customers rated the communications received from contracting officials the lowest of all contracting dimensions that were evaluated.³²³ Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care.³²⁴

Individuals in contracting believed that VAMC staff members were responsible for some of the delays in the contracting process. They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity. The VHA Procurement and Logistics Organization (PLO) and facilities are seeking to address these challenges by placing contract liaisons in facilities to better support contracting officer representatives throughout the process.³²⁵

Contracting compliance analysis showed substantial opportunity for improvement. Analysis of purchase order data showed that 38 percent of purchases were made on a government contract, 27 percent were made at open-market prices, and 34 percent did not have a source type specified.³²⁶ Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.³²⁷

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VHA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VHA's supply purchasing systems are not integrated

³²¹ The consulting team based this on an IFCAP/eCMS transmission log received during a VAMC site visit (2015). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 91, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

³²³ The consulting team derived this from a VHA procurement metrics book. McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 69, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁵ Ibid.

³²⁶ Ibid., xii.

³²⁷ Ibid.

with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VHA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.³²⁸

VHA's fragmented inventory management systems and processes also create challenges. VHA's current inventory management does not have a feedback loop to link inventory to product use, contracting, ordering, and vice versa. This lacking information prevents optimal use of the MSPV contract program and creates missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity.³²⁹

There are pockets of good performance and innovation in VHA that could be replicated across its supply chain. The *Independent Assessment Report* notes that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VHA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management. That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for veterans and for VHA.³³⁰

Talent Management

VHA is unable to hire good talent to manage its supply chain. In 2014, 20 to 30 percent of logistics positions were unfilled, and 20 percent of medical supply aide jobs were vacant.³³¹ The causes were identified as lengthy time-to-hire, nonexistent internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.³³² Examples of recent downgrades include supply technician, mail manager, administrative officer, and materials handler.³³³

*It is well known in the health care industry that there is a shortage of supply chain talent currently. The private sector organizations interviewed during this assessment stated that they are recruiting more highly trained individuals than they did in the past and, because of competition for talent, are paying them more than they used to. This may be contributing to VHA's recruitment and retention challenges.*³³⁴

In Recommendation #15, the application of the more than 60-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery

³²⁸ Ibid.

³²⁹ Ibid.

³³⁰ Ibid., xiii.

³³¹ Ibid.

³³² Ibid.

³³³ Ibid., 87.

³³⁴ Ibid., 88.

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organization. Health care supply chain management is a recognized field of study and a valued component of leadership teams at the highest performing health care organizations. For VHA to compete for top leadership talent in this field and frontline staff, logistics and procurement personnel must be included in a new excepted personnel system for VHA under Title 38 (see Recommendation #15).

To address talent management issues, VERC has established a new VA Acquisition Academy (VAAA) Supply Chain Management School.

*The mission of the Supply Chain Management School is to provide best-in-class education, training, professional development, and certification of the VA supply chain workforce. VAAA's competency-based curriculum addresses general and technical skills, VA-specific functional areas, and core activities for VA logistics professionals. Emphasis is on translating theory, fundamentals, and concepts to practical application with realistic VA-based scenarios utilizing hands-on application of problem-solving skills.*³³⁵

The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.³³⁶

Implementation

Legislative Changes

- Establish a new excepted personnel system under Title 38 to permit VHA to compete effectively with the private sector for personnel required to run a complex health care system, including staff to manage and operate a modern supply chain system.

VA Administrative Changes

- Establish an executive position for supply chain management, a VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- Transform policy and procedures for supply chain management in parallel with identification and procurement of new management software: new software should support the new processes and not the existing, poorly organized business processes and requirements.
- Establish a staged process for the transformation of all supply chain operations in VHA under the direction of a VHA CSCO, with support from VERC.
- Reconcile the VAAR with the Federal Acquisition Regulation (FAR) to ensure the VAAR aligns with recent updates to the FAR to permit streamlined acquisition processes.
- Provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR

³³⁵ "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, <http://www.acquisitionacademy.va.gov/schools/scm/message.asp>.

³³⁶ "VA Acquisition Academy Recognized as a 2016 Learning Elite Organization," U.S. Department of Veterans Affairs, accessed May 13, 2016, <http://www.acquisitionacademy.va.gov/rss/index.xml#20160413b>.

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regulations as well as a thorough understanding of their responsibilities under the new approach to supply chain management and how to carry out these duties.

Other Department and Agency Administrative Changes

- None required.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

Problem

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center (VAMC), and similar problems at multiple other VAMCs, had both direct and indirect causes. Weak governance was found to be among those indirect causes.³³⁷ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.³³⁸ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”³³⁹ The governance limitations made evident in the Phoenix

scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,³⁴⁰ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term to allow for continuity and to protect the CVCS from political transition. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

³³⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³³⁸ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

³³⁹ Ibid.

³⁴⁰ Ibid.

competing demands”³⁴¹ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

Background

VHA, as an agency within a cabinet department, is accountable to the secretary of Veterans Affairs (SECVA) and to the President. This framework, when it works well, can provide VHA access to, and support from, the President and White House staff. Like other executive branch agencies, VA and VHA undergo Office of Management and Budget (OMB) oversight; must win OMB approval of proposed rulemaking, budgets, IT development, and performance plans; and are also subject to governmentwide regulation of such areas as procurement, personnel, and property management. VHA health care and operations are subject to close congressional scrutiny.³⁴² VHA undergoes oversight from several independent bodies, including the internal Office of the Inspector General audits and external Government Accountability Office audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group, which are designated as the principal governance bodies of the department.³⁴³ VAEB serves as the department’s risk-governance board and determines VA’s strategic direction. VAEB oversees the department’s planning, programming, budgeting, and execution. Notwithstanding certain strengths inherent in this framework, VHA governance can be paralyzed by bureaucratic decision-making processes and competing stakeholder concerns.³⁴⁴

Among its principal recommendations, the *Independent Assessment Report* calls for “establishing a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.”³⁴⁵

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear. Leaders have been consumed by crisis and by responding to congressional demands, creating a reactive, rather than proactive environment.³⁴⁶ Additionally, the leadership vision has lacked continuity.³⁴⁷ The SECVA and deputy secretary of Veterans Affairs may exercise oversight of

³⁴¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴² “Legislation,” U.S. House of Representatives, House Committee on Veterans’ Affairs, accessed June 15, 2016, http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3. Over the course of calendar year 2015, the House Veterans Affairs Committee and its subcommittees alone held 18 oversight hearings relating to the Veterans Health Administration, with VHA and/or VA officials testifying as often as three times in a month.

³⁴³ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014).

³⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 26, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴⁵ *Ibid.*, 23.

³⁴⁶ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 52-54.

³⁴⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, vi-viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Linda Belton, former VHA VISN Director and Director of National Center for Organizational Development, written submission to the Commission on Care Staff, January 19, 2016.

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VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.³⁴⁸ The SECVA has often lacked independent information and metrics on VHA performance, and the oversight, risk management, and compliance functions of VHA report to the undersecretary for health (USH) or to lower officials in VHA.³⁴⁹

Previous studies, dating back 20 years,³⁵⁰ have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.³⁵¹ The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,³⁵² and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.³⁵³ Although the authors of the 1996 report presented a VHA government

³⁴⁸ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Under Secretary of Health, 38 U.S.C. § 305. While statute requires the USH of VHA to be appointed “solely on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope” there is no such selection criteria for the VA Secretary or VA Deputy Secretary. Of the eight men to hold the position of Secretary of Veterans Affairs, only one, James Peake would qualify to be USH (“United States Secretary of Veterans Affairs,” Wikipedia, accessed June 15, 2016, https://en.wikipedia.org/wiki/United_States_Secretary_of_Veterans_Affairs#List_of_Secretaries_of_Veterans_Affairs) and of the six men to hold the position of DEPSECVA, none would qualify to be USH.

³⁴⁹ Department of Veterans Affairs, *2014 Functional Organizational Manual v2.0: Description of Organization Structure, Missions, Functions, Tasks, and Authorities*, 57-58, accessed June 15, 2016, http://www.va.gov/ofcadmin/docs/va_functional_organization_manual_version_2.0a.pdf.

³⁵⁰ Veterans Benefits Improvement Act of 1994, Pub. L. No. 103-446, 108 Stat. 4645 (1994). In 1994, Congress in sec. 1104 of Public Law 103-446 called for an independent examination of the justifiability of establishing an alternative government structure to provide health care services for veterans, culminating in the 1996 report.

³⁵¹ Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. A government corporation has been described as “a government agency that is established by Congress to provide a market-oriented public service and to produce revenues that meet or approximate its expenditures.” Kevin R. Kosar, Congressional Research Service, *Federal Government Corporations: An Overview*, 2, accessed June 15, 2016, <https://fas.org/sgp/crs/misc/RL30365.pdf>. Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* September 22, 2015. Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed June 15, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>. Commission on the Future for America's Veterans, *Preparing for the Next Generation*, 3, accessed June 15, 2016, http://s3.amazonaws.com/siteninja/site-ninja1-com/1438121489/original/2014-05_Commission-Report-on-America-Veterans.pdf. That task force study, for example, called for an independent governance model and stated that “the operational structure of VHA does not lend itself to progress. Due to its size, governmental structure and geographic extension it does not readily foster innovation and faces challenges in addressing the politics of changing demographics and ancient facilities.” The study report states, “VHA provides excellence in care in spite of its operations/governance structure, not because of it.”

³⁵² Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. The strategy was premised in part on the view that VHA would be operating in a resource-constrained environment and lacked the resources it would need to invest in making significant changes.

³⁵³ Ibid. The 1996 report proposed such measures as providing VHA authority to seek additional revenue streams, to include billing and keeping funds from Medicare, Medicaid, and other government sources; authorizing it to invest nonappropriated funds; developing a trust fund for deposit of Medicare taxes by active-duty personnel; incorporating VHA as a Federal Employee Health Benefits Plan selection; allowing it to become part of health maintenance organization (HMO) networks and open HMO enrollment to veterans; changing appropriation law to create

corporation as a means of achieving specific objectives, those objectives were largely met (though ultimately not fully sustained) by reforms within existing government structures and processes set in place by former USH Kenneth W. Kizer.³⁵⁴

Nearly 20 years later, the report analyzing the root causes of delayed care at the Phoenix and other VA centers proposed creation of “governance mechanisms to bridge ‘Secretary suite’ leadership transitions and provide more stable strategy, oversight, and stewardship.”³⁵⁵ Explaining that “the study team feels that the complexity of this organization requires a more stable and professionalized governance model that more closely resembles the governance of large health care systems in the private sector,”³⁵⁶ the study authors proposed the creation of a board-of-directors-type oversight board to set the strategy for the organization, define priorities, provide operational oversight, and review budget requests. “The board would . . . create a body that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition.”³⁵⁷

Frequent turnover of the USH is a critical problem. Recently, each USH has served for only a relatively short period, leaving office with a change in administration or sooner. This pattern has deprived VHA of vitally needed sustained leadership and has likely contributed to short-term decision making. VHA history shows a connection between longer tenure and transformative accomplishment.³⁵⁸ As testimony to the Commission from three former USHs would indicate, brevity of tenure tends to limit leaders’ strategic horizon and create a pattern of leadership discontinuity. Because transformative change can only be realized through many years of focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

The complex, sustainable transformation VHA needs will take years to implement. To succeed, VHA needs strong, consistent leadership and a governance framework that can assure effective development and execution of transformation plans over time. The current governance structure emphasizes operational, rather than strategic priorities; experience has shown it to be incapable of sustaining transformational change. Establishing a well-designed, overarching-governance model would provide an opportunity to achieve objectives shared by both the executive and legislative branches.

To be effective, a VHA Care System governance model should be empowered with a governing board that exercises fiduciary-like responsibilities (not subject to the Federal Advisory Committee Act) to carry out the following key functions:

multiyear/no-year appropriations; reforming human resources management practices for increased flexibility in hiring and firing, compensation, leave, and other functions; and reforming; and reforming procurement and contracting.

³⁵⁴ Ibid., 46, 48. The Klemm report saw a VHA corporation as having greater capacity to focus on strategic as well as short term goals; greater results orientation; greater flexibility; greater capacity to replicate and develop best practices; upgraded staff competence and expertise at senior levels; and greater political independence.

³⁵⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 59.

³⁵⁶ Ibid.

³⁵⁷ Ibid.

³⁵⁸ See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).

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- select the chief of VHA Care System (CVCS) and recommend the appointment of the CVCS to the President
- provide long-term, strategic direction for VHA Care System and establish priorities, milestones, and timelines
- oversee, direct, and make critical decisions regarding the transformation process
- review and approve major operational, business, and organizational plans
- set VHA Care System performance objectives and provide annual reports to Congress and the President on VHA Care System performance
- review and make decisions regarding VHA's budget request, and independently assess and report to Congress on the adequacy of VHA budgets

New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors,³⁵⁹ referred to as the VHA Care System governing board, which is independent of department leadership to provide governance, strategic direction, decision making, and oversight of VHA Care System's operations and transformation. Table 5 provides details regarding the governing board.

Table 5. Overview of VHA Care System Governing Board

Detailed Outline for VHA Care System Governing Board	
Voting Members	The President, the majority leader of the Senate, speaker of the House, the minority leaders of the Senate and House would each appoint two members. In addition, the SECVA would serve on the Board as a voting member.
Qualifications	Members would be selected to achieve collectively broad experience, expertise, and leadership, such as experience in senior management of large, private, integrated health care systems; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans' representation. Because of the importance of veterans' representation, at least one of each congressional leader's two appointees would be a veteran; at least one of the appointees of the President would be a veteran who receives VHA care.

³⁵⁹ Michael A. Froomkin, "Reinventing the Government Corporation," *University of Illinois Law Review*, (1995): 543, accessed June 15, 2016, <http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm>. Congress need not create a government corporation to meet VHA's governance needs. The Commission notes that Congress has created entities it has called government corporations that are not predominantly commercial enterprises, rely on appropriations, and do not have the potential to become self-sustaining. A principal intention behind assigning this status and title has been to provide insulation from central management oversight agencies and the application of general management laws. When the corporation relies in whole or in part on appropriations, Congress retains the power of the purse, and the means of exercising it on matters large and small, and through formal and informal means.

Detailed Outline for VHA Care System Governing Board	
Terms	Governing board members would serve staggered terms of up to 7 years, with the governing board members electing a chair and vice chair from among the membership (other than the SECVA, who would not be eligible to serve as the chair) for 3-year terms.
Personnel Matters	Compensation would be at a rate equal to the daily equivalent of annual pay prescribed for level IV of the executive level. ³⁶⁰
Funding	Congress would provide a specific budget for the operation of the governing board as a separate account within VA's appropriations.
Relationship to the CVCS	Relationship to the CVCS: The governing board would provide the President its recommendation for a chief of VHA Care System (CVCS); the President would appoint that executive to a 5-year term; the governing board would annually review the CVCS's performance and be empowered to reappoint that official to a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. The CVCS can be removed by mutual agreement of the President and the governing board.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for governing board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the CVCS.
Powers	<p>The board would have the power to do the following:</p> <ul style="list-style-type: none"> ▪ Select the CVCS and recommend the candidate to the President. ▪ Review the performance of the CVCS on an annual basis. ▪ Reappoint the CVCS to a second 5-year term. ▪ Remove the CVCS with the mutual agreement of the President. ▪ Direct and exercise decision-making authority regarding the transformation process and operations related to the transformation process. ▪ Establish priorities, milestones, and timelines for the transition process. ▪ Review and approve major new initiatives; major operational and organizational plans (including plans regarding capital asset and facility management); strategic and business plans; and goals and metrics for operational performance and established priorities. ▪ Oversee and manage facility and capital asset strategies and operations. ▪ Review, approve, and/or amend VHA's budget requests, and independently assess and comment on pertinent elements of the President's budget, as deemed appropriate.
Reporting	The board would report annually to the President and Congress on VHA's progress toward transformation.

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A governing board structured to provide continuity of membership—as the Commission proposes through staggered terms among members—is vital. A second critical step toward assuring such continuity would be to address the tenure of the CVCS and the process for selecting candidates for that position.³⁶¹ VHA, Congress, and the President would be better served by a VHA leader who holds a 5-year term of office, with the governing board empowered to reappoint that leader to a second 5-year term.

³⁶⁰ The rate of compensation provided for members of the Commission on Care.

³⁶¹ Under Secretary of Health, 38 U.S.C. § 305. Current law provides that the Under Secretary is appointed by the President with the advice and consent of the Senate. When a vacancy in that position occurs or is anticipated, the Secretary is to convene a commission (the composition of which is set forth in the statute) which is to recommend at least three individuals to the Secretary, who is to forward those names, with any comments the Secretary considers appropriate, to the President.

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It is important that that the CVCS report to the board and function as a chief executive officer of VHA. Although the Commission envisions that the President would appoint this official, it is critical that the governing board be empowered to recommend to the President an individual for appointment when the office becomes vacant. This would replace the framework in current law that requires the establishment of a new commission convened solely to carry out the task of recommending candidates to the President.³⁶²

A governing board must be tailored to the unique needs of VHA.³⁶³ It should include members of appropriate expertise and experience to provide strategic guidance and continuity of leadership and it should possess authority to exercise the powers needed to realize and sustain a VHA transformation.³⁶⁴

Although some might consider Congress to be VA or VHA's board of directors and might question the appropriateness of establishing a VHA board of directors, this governance model does not diminish Congress's role. Instead, a board that would report periodically to congressional committees would provide a level of close oversight and health care expertise that would complement, and in many ways enhance, Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with many other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities, and establishing these and other appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

Implementation

Legislative Changes

- Amend 38 U.S.C., Chapter 3 to establish a VHA Care System governing board.
 - Amend 38 U.S.C. § 305 – which currently provides in subsection (a) for the President to appoint the USH by and with the advice and consent of the Senate, and subsection (c) for the establishment of a commission to provide recommendations for appointees for USH when a vacancy is expected or has occurred – as follows:
 - Amend subsection (a) to provide for the President to appoint the CVCS to a 5-year term of office.
 - Repeal subsection (c) of that section.
 - Provide instead for the governing board to recommend a CVSC candidate.
 - Authorize the governing board to reappoint the CVSC to a second 5-year term.

VA Administrative Changes

- None required.

³⁶² Under Secretary of Health, 38 U.S.C. § 305.

³⁶³ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 60.

³⁶⁴ The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

Other Departments and Agency Administrative Changes

- None required.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

Problem

High-performing organizations have healthy cultures in which diverse staff members feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government.³⁶⁵ For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report to the chief of the VHA Care System and the new VHA Care System governing board (also included in Recommendation #12).

Background

Healthy organizations successfully align, execute, and renew themselves through learning and innovation.³⁶⁶ They are characterized by a high level of trust, accountability, and ownership among staff; high functioning, empowered teams; and an environment that provides psychological safety and open communication, focuses on the needs of customers, and instills pride in performance.³⁶⁷ An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication helps engage employees and drive organizational performance.³⁶⁸ Engaged

³⁶⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 56, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁶⁶ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁶⁷ [http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx](http://organizationalhealth.vssc.med.va.gov/Resource%20Library/Forms/AllItems.aspx)

³⁶⁸ "Diversity & Inclusion; Federal Workforce At-A-Glance," U.S. Office of Personnel Management, accessed May 13, 2016, <https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/>.

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employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.³⁶⁹

Companies that have a healthy organizational culture or engaged staff outperform those that do not. Companies that score in the top 25 percent of organizational health metrics outperform comparable companies in the bottom 25 percent by more than two-fold.³⁷⁰ Similarly, high employee engagement is correlated with better staff and customer experiences that include higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.³⁷¹ Companies with engaged employees outperform those without by more than 200 percent.³⁷² Leaders and supervisors play a key role in establishing and sustaining employee engagement and in establishing a positive environment and culture that supports a healthy organization.³⁷³

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.³⁷⁴ This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.³⁷⁵ There are substantial impediments to moving VHA forward, however, as noted in the *Independent Assessment Report*. There is a pervasive lack of trust throughout the organization.³⁷⁶ Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.³⁷⁷ Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.³⁷⁸ The culture creates risk aversion in staff, and when cultural factors are measured in VHA, none of the metrics align with the definition of a healthy organization.³⁷⁹ Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive

³⁶⁹ U.S. Office of Personnel Management, *Strategic Plan FY2014-2018: Recruit, Retain, and Honor*, 22, accessed January 25, 2016, <https://www.opm.gov/about-us/budget-performance/strategic-plans/2014-2018-strategic-plan.pdf>. Office of Management and Budget, *Memorandum for Heads of Executive Departments and Agencies: Strengthening Employee Engagement and Organizational Performance*, M-15-04, December 23, 2014, accessed May 16, 2016, <https://www.whitehouse.gov/sites/default/files/omb/memoranda/2015/m-15-04.pdf>.

³⁷⁰ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁷¹ U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Volume 19, Summer 2013, 4-5, accessed January 25, 2016, http://www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

³⁷² U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Dee Ramsel, Improving VHA's Culture: A Presentation Before the National Leadership Council, Veterans Health Administration, December 2015, 7-9. U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 6, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁷³ Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 7-9.

³⁷⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 43, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁷⁵ *Ibid.*, 44.

³⁷⁶ *Ibid.*, 47.

³⁷⁷ *Ibid.*, 46.

³⁷⁸ *Ibid.*, 46.

³⁷⁹ *Ibid.*, 49-51.

reinforcement or clear feedback on performance.³⁸⁰ As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive³⁸¹) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies.³⁸²

Through the review of available documents and briefings from key staff, the Commission found VA and VHA have a number of activities intended to support a positive environment and culture in VHA (see Table 6), but the efforts are not systematic, integrated, or broadly deployed.³⁸³ The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these efforts and has no requirements on the VHA Central Office (VHACO) program offices to participate in the efforts.³⁸⁴ At the same time, the efforts are duplicative in that multiple offices communicate similar, but distinct messages to field staff and leaders. VHA appears to lack systematic mechanisms to ensure leaders at all levels of the organization have the knowledge, skills, and ability to create an effective culture; metrics are not comprehensive or aligned with a single-change model; and leaders in VHACO and the field are not consistently held accountable for their actions in support of a positive organizational culture.³⁸⁵

*Table 6. Cultural Transformation Efforts in VA and VHA*³⁸⁶

Program/Initiative	Responsible Office
Servant Leadership	VHA National Center for Organizational Development
Leaders Developing Leaders	MyVA
Just Culture	VHA National Center for Patient Safety
Civility, Respect, and Engagement in the Workplace (CREW)	VHA National Center for Organizational Development
Organizational Transformation Pilot	MyVA
Employee Engagement Playbooks	MyVA
VHA Voices	VHA Office of Patient Centered Care and Cultural Transformation

³⁸⁰ Ibid., 53 and 60.

³⁸¹ U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 47, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁸² Ibid.

³⁸³ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.

³⁸⁴ See “Ethical Leadership, Fostering an Ethical Environment and Culture,” National Center for Ethics in Health Care, U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.ethics.va.gov/integratedethics/elc.asp>. “Stop the Line for Patient Safety Initiative,” U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.qualityandsafety.va.gov/StoptheLine/StoptheLine.asp>. “VHA Center for Organizational Development,” U.S. Department of Veterans Affairs, accessed from VA Intranet, May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015.

³⁸⁵ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, November 20, 2015.

³⁸⁶ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31.

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VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.³⁸⁷ This cultural transformation needs to occur at all levels of the organization (VA, VHACO, veterans integrated service network [VISN], VA medical center, and community-based outpatient clinic). To achieve transformation in VHA, create a healthy environment and culture, and sustain staff engagement, the solution must start with leaders. Leaders must understand and believe in the powerful effect they have on the climate and culture in their organization. Change occurs one employee at a time. Leaders at all levels must commit to this change process. They must be inspired by top executives and embrace the values and mission of VHA and then, in turn, inspire their teams, engaging with individual employees to make change. Leaders must be given the roadmap and tools to make such change and then be supported with training, coaching, and feedback to achieve success. They must also be held accountable for their personal behavior and for the actions they take to positively influence the environment and culture of their unit or facility. Leaders should not be on their own in this transformation. Fellow leaders, outside experts, national program offices, and VA and VHA top executives must provide them with incentives, support, feedback, coaching, and, when needed, admonishment to support this cultural transformation.

To align leaders at all levels with expectations for the cultural transformation, all leaders must understand the role they play in the process. VHA must create standards for the behavior and actions leaders adopt to accomplish the transformation and widely publicize the standards among leaders and staff to establish uniform expectations across the organization and a single vision of cultural transformation. The CVCS and other senior leaders must model and reinforce these behaviors to further embed expectations. These behaviors and actions should be integrated into leadership assessment tools such as a 360 evaluation, performance management frameworks, and coaching guides to ensure expected behaviors and actions are reinforced across the leadership development and advancement system. The strategy must include the development of tools, training, guidelines, and operating procedures that create a living curriculum to support leaders in developing and deploying these new skills and behaviors. Finally, to ensure leaders at all levels implement the behaviors and actions, the strategy must establish both explicit rewards and sanctions. The rewards and recognition (nonmonetary) should liberally acknowledge and publicize leaders and staff who embody the very best standards of behaviors and actions that support a positive organizational culture. At the same time, leaders and staff at all levels must clearly understand what behavior and actions are not acceptable and be held accountable through disciplinary action if they cross these boundaries. Expectations and repercussions should be clearly articulated.

VA and VHA have a number of competing models of organizational health and staff engagement. The models are not integrated with one another or with an overall leadership competency model. Some models are robust, coupling abundant resources and training, while others are not. To create a clear focus for engagement and organizational health and guide

³⁸⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 55 accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

transformation effectively, one model must be selected for use in VHA. To do so, VHA must establish a cross functional executive team to make this decision. The team should include all of the stakeholder offices involved in current efforts, but none of them should lead the effort, to avoid parochial interests driving decisions. Once a single model is selected, the executive team must then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution, and put forward a single strategic plan. Consequently, each of those offices must also be required to stand down its own efforts that are not part of this new model going forward and align its work and budget behind a single focused model and strategy. Tools, training, and communication to support broad deployment must be part of the strategy, and the CVCS and the executive team must present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed. All leaders and staff members in the organization must understand their roles in cultural transformation and what is expected of them.

The strategy must establish and articulate a clear set of behaviors and actions expected of staff to ensure their alignment around the transformation. The standards should be incorporated into the hiring process to ensure that VHA is hiring into the new culture and avoids a poor fit from the start. These behavioral expectations must be articulated clearly in the on-boarding process and reinforced on an ongoing basis in performance evaluations, reviews, and individual development plans. Leaders at all levels of the organization must also reinforce these behavioral expectations with staff and be provided with tools, messages, and communication support to accomplish this. Leaders must also recognize and reward the positive examples of the desired behaviors and sanction the worst examples, up to and including discipline and removal.

The change strategy should also recognize that cultural transformation and staff engagement go beyond individual leader and staff behaviors. Systems and processes at both the local and national level can impede the realization of the positive organizational culture desired. As such, the transformation strategy must also anticipate changing systems and processes as an explicit component of transformation. Leaders at all levels must establish mechanisms to elicit staff concerns and have quality improvement tools in place to address them, such as LEAN Six Sigma. Line staff must be engaged as part of the solution to these system issues. Leaders should be transparent about these issues and publicly track and report on progress.

To ensure the effective execution of this strategy, specific responsibilities must be assigned to program offices. The program offices must also support the VISN and facilities in their transformation effort by developing the standards and guidance for them to use and making program office expertise available to support coordination, coaching, and sharing of best practices across the institution. The program offices must be held accountable for supporting the application of these same standards and process within VHACO.

Standards for facility implementation must include a funded, full-time equivalent employee to support each major facility director³⁸⁸ and be the point person to coordinate efforts with VHACO and other facilities. Facilities may take the opportunity to consolidate related functions that currently exist in the facility. Each facility must have a local mechanism, such as an organizational health council, to integrate and drive transformation locally. But this does not

³⁸⁸ This equates to one person at each of the approximately 141 VHA health care systems led by a facility director.

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mean the facility should create yet another committee or oversight group to accomplish the transformation. Instead, facilities must look to existing leadership structures and activities, consolidating similar efforts to create an efficient process.

Finally, the executive team must oversee the development of a consolidated and meaningful set of metrics, using community standards where available, to track cultural transformation, organizational health and staff engagement. The metrics should not only measure the desired outcomes but also provide insights to leaders on how to fix problems by providing sufficient detail and specificity to offer this insight. Once deployed, the metrics should be used by the executive team and responsible program offices to identify under-performing facilities and to provide additional expertise, resources, and support to help those facilities improve. If, after much support, the continuing behavior and actions of the leaders at the under-performing facility are identified as the cause of the long-term culture problem, these individuals must be removed from leadership positions in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the CVCS with long-term responsibility for creating, executing, and tracking the cultural transformation.
- Align frontline staff in support of the cultural transformation strategy.
- Require standards and a strategy for execution of the cultural transformation from every program office and facility and these efforts must be fully funded.
- Develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users.

Other Department and Agency Administrative Changes

- None required.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

Problem

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an Office of Management and Budget management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Background

*Our Corps does two things for America: We make Marines and we win our nation's battles. Our ability to successfully accomplish the latter depends upon how well we do the former.*³⁸⁹

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.³⁹⁰ The most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.³⁹¹ This need is driven by a changing workforce that is motivated more by passion than by monetary incentives, a rapid advance in knowledge that quickly creates obsolescence, and technology drivers that change business practices over months instead of years.³⁹² Investing in new supervisors and emerging leaders is critically important because

³⁸⁹ U.S. Marine Corps, *Sustaining the Transformation*, Foreword, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20206-11D%20Sustaining%20the%20Transformation.pdf).

³⁹⁰ Jim Collins, *Good to Great: Why Some Companies Make the Leap . . . And Others Don't* (New York, NY: HarperCollins Publishers, Inc., 2001), 17-40. Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015).

³⁹¹ Deloitte Consulting LLP and Bersin by Deloitte, *Global Human Capital Trends 2014: Engaging the 21st Century Workforce*, 25, accessed June 10, 2016, http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf.

³⁹² *Ibid.*, 3.

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employees report that when they quit a job they leave their supervisors and not their organization.³⁹³ In an organization like VHA, with more than 300,000 employees but only a bit more than 200 executives, VHA's 28,000 supervisors are responsible for leading the staff.³⁹⁴

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.³⁹⁵ Staff members who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.³⁹⁶ Yet, the skills needed to be a successful leader are different than those needed to be a successful technical expert. Today, soft skills such as empathy, effective listening, and team coaching are valued in leaders.³⁹⁷ The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others.³⁹⁸ An effective leadership system develops leaders at all levels, from frontline supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."³⁹⁹

Analysis

In a review of VHA's approach to leadership development, the *Independent Assessment Report* noted the current system was not sufficient to meet VHA's need for high-quality, prepared leaders.⁴⁰⁰ VHA lacks a comprehensive approach to leadership development that would include formal structured programs such as networking, reflection, goal setting, learning, mentoring, experiential learning, and a clear career ladder. As a result, leaders are unable to fully prepare

³⁹³ "People Leave Managers, Not Companies," Victor Lipman, accessed June 10, 2016, <http://www.forbes.com/sites/#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3>.

³⁹⁴ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 21-23, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

³⁹⁵ U.S. Merit Systems Protection Board, Office of Policy and Evaluation Perspectives, *Federal Supervisors and Strategic Human Resources Management*, accessed June 10, 2016, <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT>.

³⁹⁶ Ibid. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁷ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. "Creating and Retaining Great Leaders," Dominique Jones, accessed June 10, 2016, <http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419>. "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>.

³⁹⁸ Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015). "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁹ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. U.S. Marine Corps, *Sustaining the Transformation*, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20percent206-11D%20Sustaining%20the%20Transformation.pdf).

⁴⁰⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

for future roles.⁴⁰¹ Although VHA does have some components of a development program, the activities are not connected to a career path and not well coordinated. Comprehensive development efforts are impeded by the use of multiple competing competency models in VA that make it impossible to align assessment and development with a cohesive standard. Emerging leaders are left to navigate career progression largely on their own and may be stymied because development opportunities are cancelled due to budget restrictions. Even when promising young leaders complete the current activities, gaps remain in their experience and training because the training programs are not coordinated.⁴⁰² As a result, VHA does not have a robust pipeline of young leaders ready to take on higher-level responsibilities.⁴⁰³

Included in the *Independent Assessment Report* is a recommendation that VA stabilize, grow, and empower leaders. This recommendation includes suggestions to fill current vacancies with high-quality leaders, improve the attractiveness of the roles, ensure leaders are prepared to assume their roles, and create a comprehensive strategy that connects top performers to leadership opportunities and development plans.

There is little concrete information in the assessment to suggest how VA and VHA should accomplish these objectives. The commission examined VA's and VHA's current work to assess whether they have created plans to operationalize the leadership development recommendations articulated in the *Independent Assessment Report*.

Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.⁴⁰⁴ Having a cogent competency model is a prerequisite to a coherent strategy.⁴⁰⁵ Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.⁴⁰⁶ Thus, any competency model applied in VHA must include health care specific components. Health care executive competencies embrace such topics as an understanding of ethics in health care, management of self-governing professionals (e.g., physicians, nurses), the technical knowledge of health care regulation and operational management, and leading change, in addition to other leadership skills and knowledge.⁴⁰⁷

The current models used in VHA do not reference external benchmarks, and they are not health care specific. VHA plans to continue to use the High Performance Development Model (HPDM) as its competency model.⁴⁰⁸ HPDM was developed by VHA and is not benchmarked to private-sector competency models for health care executives. VHA plans to use the model to drive

⁴⁰¹ Ibid.

⁴⁰² Ibid., 38.

⁴⁰³ Ibid., 37.

⁴⁰⁴ The American College of Healthcare Executives, *ACHE Healthcare Executive: 2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid. "Joint Medical Executive Skills," Joint Medical Executive Skills Program, U.S. Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁰⁸ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

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position requirements, performance management, and training content.⁴⁰⁹ The plan mentions coordination with VA Learning University but provides no detail.⁴¹⁰ The plan also does not provide specific information about how the use of HPDM will link to formal recruitment, performance assessment, and advancement of leaders.⁴¹¹

VHA is working to understand the current career progression of candidates who move into field-based executive positions. VHA field leaders are cultivated from within VHA with about 98 percent advancing from lower-level field positions such as associate director, service chief, or chief of staff.⁴¹² As a result, field senior executives often lack outside experience and first-hand knowledge of alternative management methods.⁴¹³ Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.⁴¹⁴ For instance, Henry Ford Health System, a successful growing company with a robust internal leadership development program has set a target of 70 percent internal promotions and 30 percent external hires.⁴¹⁵

The VHA pool of internal candidates is also deficient in racial and ethnic diversity with striking under-representation of women of color in all of the positions that constitute the pipeline for medical center director positions (see Figures 6 and 7).⁴¹⁶ VHA leadership development programs have failed to effectively recruit and advance under-represented minorities with a striking over-representation of White men in the leadership class that feeds the senior executive service (see Table 7).⁴¹⁷ Minority women shoulder the biggest burden of formal mentoring within the organization.⁴¹⁸ VHA also has the lowest representation of veterans among its staff (31 percent) compared to Veterans Benefit Administration (52 percent) and National Cemetery Administration (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees.⁴¹⁹ Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.⁴²⁰

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

⁴¹² Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹³ Ibid.

⁴¹⁴ Eric Krell, “Staffing Management: Look Outside or Seek Within?” *HR Magazine*, January/February 2015.

⁴¹⁵ “NCHL Health Leadership Competency Model,” National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

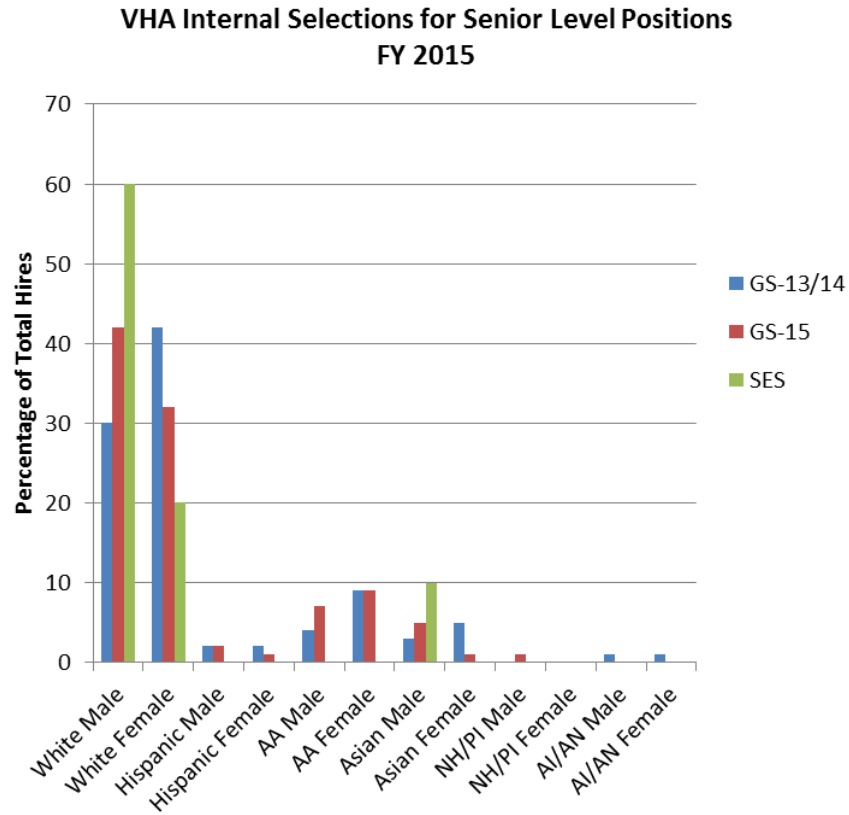
⁴¹⁶ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

⁴¹⁷ Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹⁸ Ibid.

⁴¹⁹ Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.

⁴²⁰ VHA Health Care Talent Management Office, provided to Commission on Care for employees in VHA as of September 30, 2015 by request, March 8, 2016.

Figure 6. Diversity of Senior-Level Hires in VHA

AA = African American

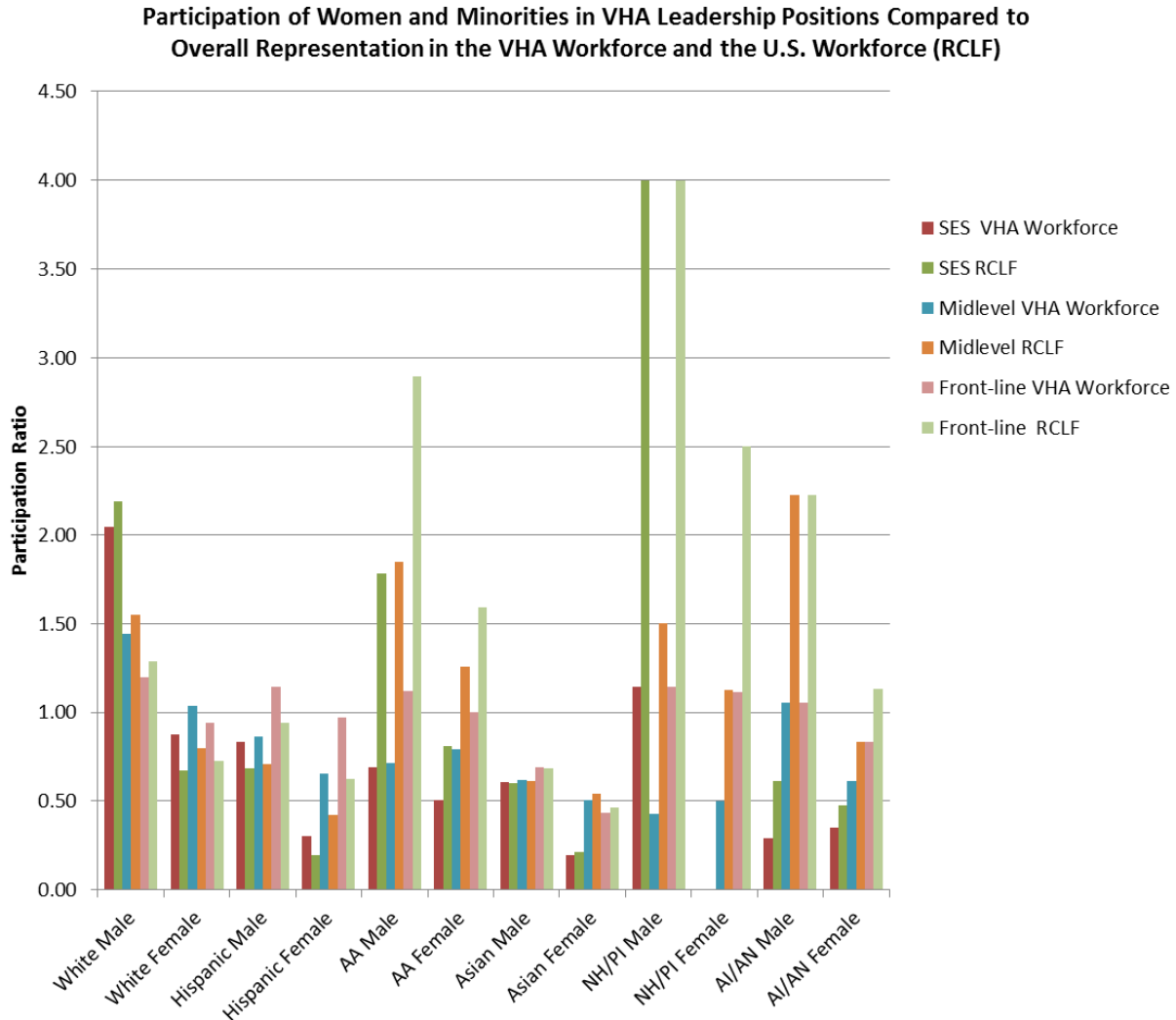
NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: In FY 2015, VHA failed to select many candidates from diverse racial and ethnic backgrounds for senior executive positions. These data were drawn from the VHA annual equal employment opportunity (EEO) report.

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Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA



AA = African American

NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: Women and particularly minority women are under-represented in comparison to their participation in the U.S. workforce (relevant civilian labor force [RCLF]) and their participation in the VHA workforce at higher levels in the organization. Some minority men are also under-represented in high-level positions. These data were derived from the VHA annual EEO report.

Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP

	TCF 2015 (N)	GHATP 2014 (N)	Facility LEAD 2015 (N)	VISN/CO LEAD 2015 (N)	HCLDP 2015 (N)	VHA Workforce
White Male	35% (78)	30% (14)	19% (160)	22% (69)	41% (151)	23%
White Female	16% (35)	28% (13)	41% (342)	41% (127)	39% (144)	36%
African American Male	15% (33)	9% (4)	8% (66)	8% (24)	4% (14)	9%
African American Female	19% (42)	15% (7)	22% (180)	16% (50)	6% (23)	15%
Hispanic/Latino Male	4% (10)	4% (2)	3% (23)	4% (11)	1% (5)	3%
Hispanic/Latina Female	3% (7)	2% (1)	3% (29)	3% (10)	1% (4)	4%
Asian Male	4% (9)	2% (1)	1% (9)	>1% (2)	2% (7)	3%
Asian Female	2% (5)	9% (4)	2% (16)	4% (13)	3% (12)	5%
Native Hawaiian/Pacific Islander Male	0% (0)	0% (0)	>1% (3)	0% (0)	0% (0)	>1%
Native Hawaiian/Pacific Islander Female	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	>1%
American Indian/Alaska Native Male	2% (4)	0% (0)	>1% (1)	>1% (2)	1% (3)	1%
American Indian/Alaska Native Female	0% (0)	0% (0)	1% (7)	1% (4)	1% (3)	1%

Note: VHA offers career development opportunities from entry-level programs (TCF and GHATP) to an SES preparatory curriculum (HCLDP). Overall, White men make up about 23% of VHA employees but are over-represented in the HCLDP program at 41%. African American and Hispanic men and women are under-represented in the same program.

TCF= Technical Career Field; GHATP=Graduate Healthcare Administration Training Program; LEAD=Leadership, Effectiveness, Accountability, and Development; HCLDP=Health Care Leadership Development Program.

No evidence was presented to indicate that career progression mapping is occurring for positions within VHA central office, where high-quality leaders are also required.⁴²¹

⁴²¹ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

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VHA has much work to do to produce an effective leadership management system. Recruitment, retention, development and advancement are key processes that require immediate and sustained attention from VHA leaders. Without substantial changes, high-potential staff will continue to struggle to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without uniform standards against which to measure applicants and new executive hires will continue to struggle to understand VHA and their role in leading it. Without the committed engagement and support of the chief of VHA Care System (CVCS) and the other top VHA executives for the leadership management system and their direct communications about and modeling of the leadership competencies, VHA will continue to flounder. As a result, veterans will be denied the high-performing health system they deserve.

Executive Commitment

The long-term success of any enterprise rests on having excellent leaders in key positions and sustaining them over time. To accomplish this goal, leadership management, development, and recruitment must be a core responsibility and a priority for VHA senior executives. To start, VA must include the goal of achieving an effective leadership management system in VHA as a component of the department's management agenda in the annual budget. The goal is a robust, high-quality, diverse leadership team in VHA. VA needs to establish a credible operational plan and accountability mechanisms for meeting this goal. Executive leaders are then held accountable for attaining the leadership management goals, including personally investing time in meeting diversity targets, recruitment plans, and succession planning objectives. These targets are to be reviewed in the individual performance of top leaders as well as in the Office of Management and Budget's ongoing review of the department's management objectives. Executive leaders need to also set and communicate clear expectations for the behavior of leaders and staff and to invest their own time in mentoring, coaching, and developing subordinate leaders and promising staff, including under-represented populations. They must be visible and role-model leadership competencies in meetings, training, and new-hire orientations. They must take an interest in developing leaders and help create opportunities for them to gain leadership experience and competencies. The CVCS and senior executives must keep in mind that their sole role is not to manage crises or to oversee a process or to manage up. Rather, their primary role is to lead their people. Their time and attention must reflect that priority.

Leadership Model

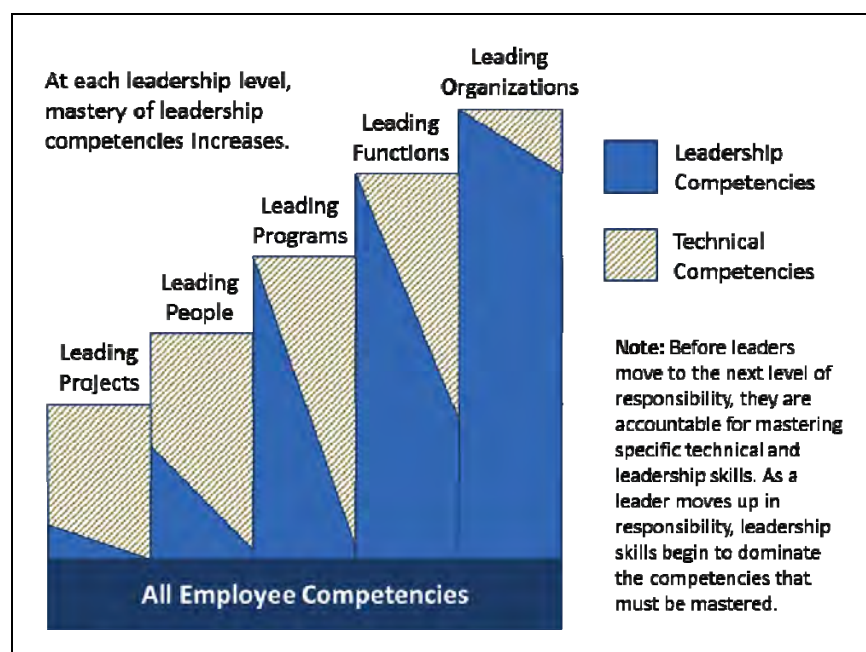
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one benchmarked health care competency model. Currently, VHA is subject to the Office of Personnel Management executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high-potential staff to follow, and they do not provide opportunities for VHA to intersect with leaders in the private sector. VHA must stop using these varied competency models and instead adopt a single model that is benchmarked to private-sector standards. The Commission is not making a recommendation about which model VHA should choose. Rather VHA should apply the criteria below to select a model around which to base its leadership development program:

- The standard must embrace leading through ethics and values, demonstrating character and concern for others, and creating a strong organizational culture.
- The standard must be health care based and describe the knowledge, skills, ability, and leadership bearing and behaviors that health care leaders must master to be effective.
- The standard must be a robust competency model including aligned training and tools to permit quick implementation.
- The model must describe different career tracks and the mastery requirements for key points in each career track. Key career tracks such as VISN director, facility director, and VHA Central Office (VHACO) program executive should fit into the competency model.
- A career path must specify the competencies that require mastery before moving to a higher position.
- VHA may need to enhance the model with competencies in care and services to Veterans and knowledge of military occupational health.

Training and Assessment

VHA needs to develop assessment tools based on the competency model, including 360, 180, self-assessment, and supervisory review processes. Leaders and developing leaders should be required to use at least one of the assessments each year and to apply the results to identifying their training and development needs. Findings from the assessments should be rolled into an individual development plan (IDP) for each leader or developing leader and enrollment in a leadership course should require a documented need from one of these assessments.

Figure 8. At Each Leadership Level, Mastery of Leadership Competencies Increases



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Training must be mapped against the competency model career track. All current leadership training should be mapped against the model. Gaps should be identified and filled with commercially available, or where needed, internally developed training. This training should include leadership competencies for the care of veterans, including an understanding of military occupational health, combat injuries and exposure, combat readjustments, and military sexual trauma. (See Appendix H for descriptions of such training material.) VHA should look for opportunities to partner with Department of Defense and the private sector to provide joint training and development opportunities to fill some of the identified gaps. VHA must develop one or more face-to-face training series that allow high-potential candidates to complete all the competencies required to move to the next career stage. As VHA strengthens its partnership with community providers and health systems, executive and high-potential training resources from VHA should be made available to community health care leaders and VHA should join training offered by these private-sector partners.

Based on the benchmarked competency model, VHA should collaborate with Academic Affiliates to establish two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run these programs with the goal that all participants rotate in management positions in VHA or VHA-partnered private-sector systems for six or more months during their training. Graduates of such programs would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for any direct funding provided.

All training should include formal assessment to assure that learners have mastered the material and this mastery should be noted in their IDPs and training record.

As part of the leadership development model, experiential learning opportunities and formal coaching are critical to executive learning. Individual and group coaching standards and programs must be established for all developing and new leaders. A program for senior leaders to pair them with private-sector health care leaders must also be supported. VHA must establish rotation opportunities for developing leaders to rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. This program could be structured as a certificate program that the employee and VHA jointly fund and include a payback commitment on the part of the trainee. Similar rotations from the private sector into VHA should be developed with health care system partners to help develop private-sector competencies in care for veterans and inject private-sector approaches into VHA.

Apply the Leadership Model

VHA is required to apply the competency model in all hiring decisions for executive career field positions. Thus all functional statements must be based on the model, all interview protocols must incorporate the competencies, and all candidates who are not internally certified to the standard of the job must undergo an assessment by a board to ensure they meet the position requirements. Conversely, internal candidates must be required to demonstrate mastery of the competencies before qualifying to apply for a position. VHA must adopt the strategies of executive recruiters to identify and recruit needed experts outside of government with the

competencies VHA seeks. Recruiters can look to the pipelines the Commission has recommended building to bring military treatment facility commanders and other senior leaders and private sector experts into VHA as a network for identifying additional recruits. Executive recruiters can particularly help ensure diverse candidates are identified for open positions.

VHA will require competency assessments and IDPs for all existing executives, potential executives, and new hires. Current leaders and new hires who have an identified gap in any competency must have it included in their IDP and be required to fill these deficiencies by a specific deadline or face demotion or dismissal. Completion of IDP development opportunities is required for advancement in grade or promotion to higher position within the leadership pipeline.

VHA will aggressively manage its leadership candidate pool by identifying and tracking all high-potential individuals. Diversity statistics should be tracked and diversity in this pool actively managed. This pool of candidates derives from annual ratings as well as leadership development program graduates. Supervisors and executive leaders must provide ongoing coaching for higher positions to this pool of developing leaders. VHA must identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Once the positions are open, individuals in the high-potential pool must receive notices of new job postings and detail opportunities that provide experience into higher positions. Candidates who agree to be in this pool should be required to enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level positions (VISN director, facility director, VHACO chief officer) a formal pool of approved or precertified candidates should be established.

To expand the perspectives and management experience in its leadership pipeline, VHA must develop explicit strategies to on-ramp diverse candidates at critical midcareer transition points. This process includes creating pathways for retiring commanders and other senior officers of military treatment facilities to compete effectively for leadership positions in VHA. To increase VHA understanding of private-sector health care, VHA must develop midcareer entry points for private-sector candidates. This could be accomplished through the use of temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competencies standards have been met by the candidates. Such opportunities can be modeled on efforts recently announced by DoD and, wherever practicable, should be developed collaboratively with DoD to establish the legal and policy requirements for implementing these programs. Finally, the current graduate health administration training program (GHATP) program should be expanded to include more schools and programs with diverse trainees. This expansion must allow high-performing residents to continue to convert to full time positions.

On-boarding

A formal on-boarding process should be instituted for all new executive hires. In addition to the transactional knowledge the individual will need, on boarding should establish the expectations for what it means for that executive to be successful in VHA. The values of the organization and the expectations for ethical practice must be conveyed by the CVCS and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding and an IDP established to cover the probationary period of new hires if any deficiencies are identified.

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Completion of the IDP is required for continued employment. All new leadership hires should be assigned a coach based on their individual needs. Within their first 6 months of employment, the undersecretary for health and Secretary should meet with these new executives to build a relationship with them and hear their fresh perspectives on the performance of VHA.

Stabilize Leadership

VHA should immediately stabilize its leadership ranks by authorizing VA medical center and veterans integrated services network (VISN) director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA should also create flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN chief medical officer, assistant nurse executive, deputy chief officer). These individuals would comprise the pool of potential leaders and also allow for cross filling positions that are empty due to development assignments, training, or other leadership development opportunities.

Implementation

Legislative Changes

- Establish direct-hire authority from the graduate health care administration training program, military treatment facility, and private-sector fellow pools, clarifying application of merit-system principles, including approaches to managing veterans' preference in these programs.
- Establish Intergovernmental Personnel Act authority for VHA to include the for-profit private sector; this could be done as a pilot program with a report to Congress before considering whether to make the authority permanent.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.
- Aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: All hires and promotions are required to demonstrate these competencies.
- Require a formal on-boarding process for HPDM 3 and 4 leaders at all levels that reinforces the leadership competency model.
- Take immediate steps to stabilize the continuity of leadership by extending the length of authorized details to extend the continuity of leadership at medical centers and allow leaders detailed to a position to compete for a permanent appointment to the position by removing the non-compete requirements.

COMMISSION RECOMMENDATIONS

- Establish the competency model in regulation and include requirements for its use in hiring, promotion and dismissal and clarify the application of veterans' preference in executive development.

Other Department and Agency Administrative Changes

- None required.

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Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Problem

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative. The role of the Veterans Integrated Service Network (VISN) is not clear, and the delegated responsibilities of the medical center director are not defined.

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.⁴²² An organization's leadership system is "the way leadership is exercised, formally and informally, throughout the organization; the basis for key decisions and the way they are made, communicated, and carried out."⁴²³ It includes "structures and mechanisms for making decisions; ensuring two-way communication; selecting and developing leaders and managers; and reinforcing values, ethical behavior, directions, and performance expectations."⁴²⁴ In an organization the size of VHA, with a budget of \$69 billion,⁴²⁵ more than 300,000 employees, and more than 1,000 sites of care,⁴²⁶ strong leadership systems are essential.

The Commission Recommends That . . .

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve Veterans Integrated Service Networks (VISNs) and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the chief of VHA Care System with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report (also included in Recommendation #10).

⁴²² Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 50.

James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't*, (New York, NY: HarperCollins, 2001), 17-64.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Department of Veterans Affairs, *VA 2017 Budget Request: Fast Facts*, accessed March 10, 2016, <http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf>.

⁴²⁶ "About VHA," Department of Veterans Affairs, accessed February 5, 2016, <http://www.va.gov/health/aboutVHA.asp>.

In the last successful reorganization of VHA in 1995,⁴²⁷ the organizational design and functional roles of the leadership system were organized into clear structures with clear functions. The VISNs were responsible for operations⁴²⁸ and VHACO program offices were responsible for policy, guidelines, and outcomes.⁴²⁹ The National Leadership Board (made up of VISN directors and all program office leaders) was responsible for collective, fact-based decision making and the Friday Hotline call was used to communicate leadership priorities and decisions directly to VA medical center (VAMC) leadership. A negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics⁴³⁰ was also established that was supported by centralized functions that benefit from economies of scale.⁴³¹ As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.⁴³² Because this functional matrix was not sustained, VHA now faces the challenge of reinstituting an effective leadership system.

Analysis

Twenty years after the Kizer reorganization, VHA has a very different leadership system, under which it “is intensely, unnecessarily complex due to a lack of clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.”⁴³³ The *Independent Assessment Report* included the following findings about the VHA operating model:⁴³⁴

- VHACO has grown rapidly since 2009 from 753 in FY 2009 to 1,990 in FY 2014.
- The VISNs’ ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs’ operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA’s increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

VHACO has grown rapidly in the past few years.⁴³⁵ The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new

⁴²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berrett-Koehler Publishers, Inc., 2012), 54.

⁴²⁸ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 35. Kizer, Kenneth W and Ashish Jha, “Restoring Trust in VA Health Care,” *New England Journal of Medicine*, 371, (2014): 295-297.

⁴²⁹ Ibid.

⁴³⁰ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72.

⁴³¹ Ibid., 33.

⁴³² Ibid., 60. Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System*, Objective 3 and 17, 1996.

⁴³³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 95, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴³⁴ Ibid.

⁴³⁵ Ibid., 98.

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offices and new staff infrastructure to support it.⁴³⁶ A portion of the growth came from the centralization of functions that were previously managed in the field such as business office functions. The final component has come from the duplication in VHA of offices in which decision-making authority rests with VA, such as communications and regulatory management. VHA has also duplicated functions and responsibilities between two or more offices in VHA, such as primary care, surgery, mental health, and geriatrics and extended care. This increased growth in staff and offices has resulted in more complex and lengthy decision processes, often with little clarity as to whom ultimate responsibility for decisions or follow up falls.⁴³⁷

One symptom of the top-down management is VHACO control of budgeting and resource management. “Support funding is outside local control” and the “increasing share of Specific Purpose funding hinders” local leaders in their ability to use resources effectively.⁴³⁸ In FY 2015, specific-purpose funds were spread across more than 450 line items,⁴³⁹ taking money away from general purpose funding and restricting how this money can be used. Both VHACO and Congress have been complicit in taking control away from medical center directors through these budget controls.⁴⁴⁰ For instance, the congressional appropriation to fund VHA for 1998 included only five appropriation line items; medical care, medical administration, construction major, construction minor, and medical and prosthetic research.⁴⁴¹ In contrast, the budget request to Congress for FY 2016 included 12 budget categories relevant to VHA with some of those accounts having four or five subcategories.⁴⁴² In his testimony before the Commission and Congress, Secretary McDonald made the point that such fragmentation of the VHA budget and the prohibition to reallocate across budget categories without first receiving Congressional approval was an impediment to effective and agile management of the department.⁴⁴³ Greater Congressional control of VHA spending is understandable in light of VA’s lack of adequate management systems and data analytic capabilities to track expenditures in real time⁴⁴⁴ and report them to Congress and central office. The only means available to hold the medical centers

⁴³⁶ Ibid., 96-99.

⁴³⁷ Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 7-9.

⁴³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴³⁹ Ibid., 107.

⁴⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102-108, accessed June 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴⁴¹ PL 105-65, October 27, 1997.

⁴⁴² Department of Veterans Affairs Fiscal Year 2016 Budget Submission, Volume II Medical Programs and Information Technology, Accessed June 10, 2016, <http://www.va.gov/budget/products.asp>.

⁴⁴³ On January 21, 2016, Secretary of Veterans Affairs, Robert A. McDonald, provided the following testimony before the U.S. Senate Committee on Veteran’s Affairs “Flexible Budget Authority: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA’s budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.” accessed June 10, 2016,

<http://www.veterans.senate.gov/imo/media/doc/VA%20Sec%20Testimony%2001.21.2016.pdf>

⁴⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 105, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

accountable was to fund the priority initiatives as separate budget lines or indicate allocations to be made under the specific-purpose process.

To fix the overly complex and bureaucratic structure of VHA, the *Independent Assessment Report* suggests that VHA “redesign (its) operating model to create clarity for decision-making authority, prioritization, and long-term support.”⁴⁴⁵ VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:⁴⁴⁶

- fact based, innovative decision making that is responsive to the field, other offices, and external stakeholder requirements
- feedback mechanisms to incorporate system learning into policy development and operational guidance
- communication mechanisms to effectively share information across offices and reach VISN and facilities to explain expectations and tie decisions to organizational values and goals
- effective execution of policy decisions through expert coaching, deployment of resources, and guidance based on external benchmarks and sharing of internal best practices
- analytic capability and infrastructure to effectively monitor progress and outcomes of all organizational priorities

Such a reorientation will involve a different skill set and expertise than currently required in VHACO. Transformation will call for recruiting new expertise, making advancement decisions based on these new competencies, reinforcing them through recognition and performance assessment, and developing new skills in current staff through training and coaching. This skill set includes a high level of technical expertise relevant to the program office; the ability to build relationships with external stakeholders; demonstrated skills in coaching, staff development, and training; certification in quality improvement methodologies; analytic capabilities to develop and track metrics; and the ability to lead transformational change. VHA must fully fund the retraining and the hiring of skilled staff in VHACO to accomplish this transformation.

For the VHACO program offices to work effectively with one another and with the field, the specific authority of each office must also be defined. Where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can take the opportunity to align functions to achieve its stated priority of patient-centered care. In a fully aligned operating structure, business processes from the VAMC front line to central office must be organized to deliver important

⁴⁴⁵ Ibid., ix.

⁴⁴⁶ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 7, 34, and 50.

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patient outcomes rather than aligned in professional silos. For instance, instead of having an office of nursing, one for social work, and a lead for physician assistants, business offices should be aligned around the work they do together, like patient aligned care teams, to deliver positive outcomes for veterans.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to discuss and make decisions rather than relying on bureaucratic, paper-based processes as a means of negotiation: It is neither a healthy culture nor an efficient process. At the same time, VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition package development, recruitment package development, and account reconciliation so that staff is not required in each program office to take on these occasional but complex activities. The net savings resulting from this reorganization and delayering of the bureaucracy must be reinvested in the transformation process.

VISNs must also examine the skills needed to take on an expanded role as facilitators, coaches, and guides in improving services and sharing best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify ineffective processes, problems, and emerging issues that need to be raised to VHACO for help in clearing away barriers to effective operations. Similar to VHACO, VISNs must define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation as well as training and coaching staff to develop these competencies. Finally, the chief of VHA Care System (CVCS) should establish a required staffing ratio for the VISN office and reduce the staffing in VISNs that exceed this standard.

A new operating model also means that medical center directors must control the budget, staff, supplies, and infrastructure required to deliver needed health care. This model includes consolidation of budget lines and new authority and expanded authority to reallocate funds across the remaining budget categories. To manage the new VHA Care System and ensure that facility and network directors have the local control needed to make decisions about how to deliver services, fewer restrictions should be placed on the VHA budget. To start, specific-purpose funds must no longer be used to direct obligations at facilities. Congress should also work with the administration to reduce the number of budget lines and specific spending authorities back to a simpler system like that used in 1998. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by effective financial management data systems and fully trained staff and leadership who understand how to use such systems.

To support the leaders, program offices, and the field in this transformation, the CVCS must establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. Existing offices with the requisite expertise, including the Office of Strategic Integration and the Veterans Engineering Resource Center (VERC), should be rolled into the transformation office. This office would oversee transformation and incubate new initiatives with the goal of incorporating them into regular work of other program offices once the new initiative is established. This mechanism, if used consistently, would prevent VHA from growing new offices as new priorities arise.

Finally, as part of cultural change within the leadership system, the CVCS, VISN directors, and program office leaders must promote open and productive dialogue among themselves about problems and solutions. To accomplish this goal, leaders must address both the culture within the leadership ranks, as well as establish systems and processes that support identification and discussion of problems. The CVCS must model this behavior by inviting input on problems and rewarding leaders when they bring issues forward, including rewarding them with access to expertise, staff, and money; removing barriers; and aligning other leaders in support of solutions.

In its work to oversee change in VHA, the transformation office will create an implementation plan for transformation, identifying key strategies and milestones. This plan will drive data collection, development of strategic goals and supporting objectives to encourage effective planning, accountability, and the ability to unearth critical gaps that need to be addressed. The transformation office will require each new initiative to establish a project plan and provide periodic reports that include all of the following components: tactic/action, initiative owner, cost (i.e., operational, equipment, contracts), number of FTEs, start and completion dates, outcome measures, strategic drivers, and milestone.⁴⁴⁷ The President's Management Agenda Scorecard will serve as the evaluation model. The Office of Management and Budget created this tool to evaluate new initiatives and track progress on outcomes over time with regular spotlight reports (red, yellow, green) to leadership.⁴⁴⁸

Implementation

Legislative Changes

- Simplify the VHA budget to include fewer accounts while at the same time requiring more transparent and detailed accounting of VHA expenditures.

VA Administrative Changes

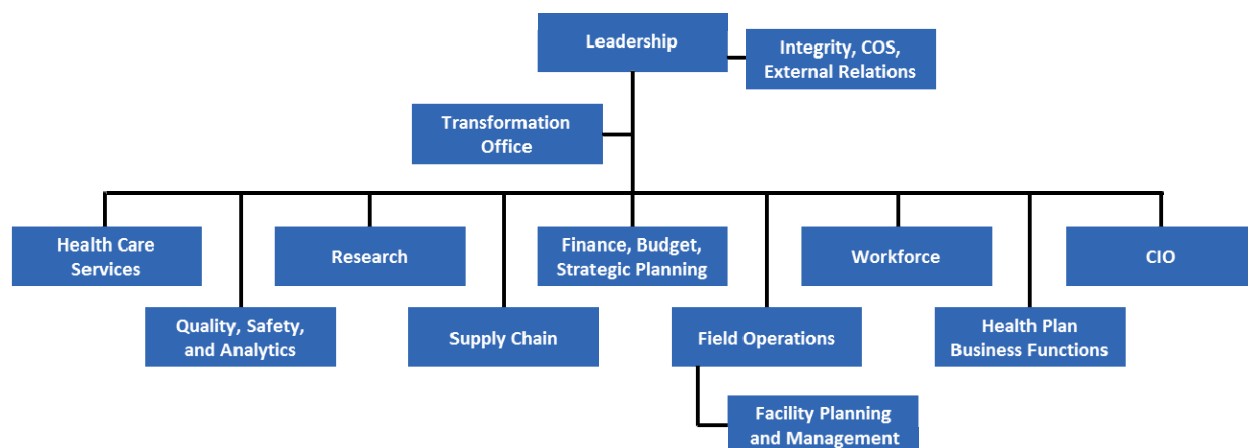
The following administrative changes are a priority during the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B. Responsibility for establishing a transformation plan with milestones, timelines, and evaluation of outcomes is assigned to the transformation office that the Commission recommends be established in VHA.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. Figure 9 is one model of an organizational chart for accomplishing this goal. This organizational chart shows how VHA can be streamlined to mirror the structure of large private-sector hospital systems. Figure 10 is the current VHA organizational chart, provided as a point of comparison and to emphasize the cumbersome nature of the current structure.

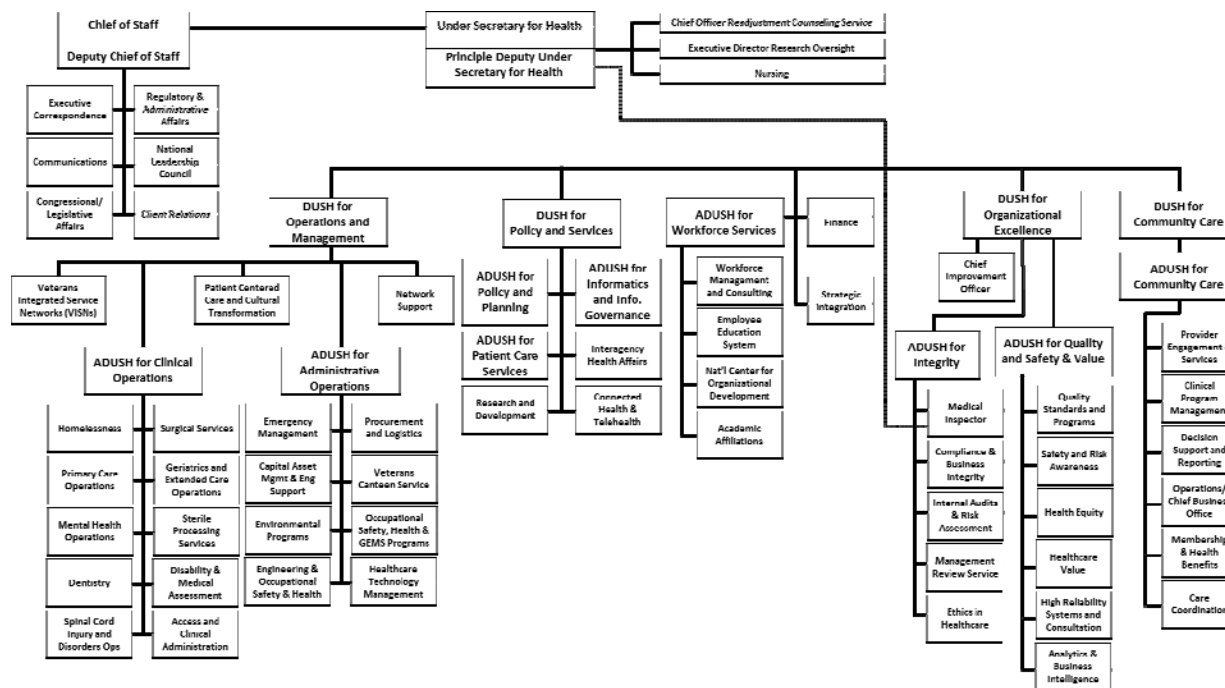
⁴⁴⁷ For example, see "VA Faith-based and Community Initiative President Management Agenda Scorecard," September 30, 2008,

⁴⁴⁸ "Office of Federal Financial Management President's Management Agenda," Office of Management and Budget, accessed June 15, 2016, https://www.whitehouse.gov/omb/financial_fia_pma/.

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Figure 9. Proposed VHA Organizational Chart⁴⁴⁹

Note: This organizational chart is an example of how to align VHA functions to create a flatter organization, remove duplication, and streamline decision making as discussed throughout this section of the report. Of note, the placement of the Transformation Office, CIO, and supply chain in this diagram is consistent with recommendations made by the Commission elsewhere in this report. In this chart, COS is chief of staff.

Figure 10. Current VHA Organizational Chart⁴⁵⁰

⁴⁴⁹ Modified from Appendix C, Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 41.

⁴⁵⁰ Ibid.

COMMISSION RECOMMENDATIONS

- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- Create innovative organizational structures that are aligned to patient's needs rather than professional silos, to support clinical care.
- Undertake a reduction-in-force in VHACO that facilitates delayering and efficiency in communication and decision making.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA. The transformation plan is to capture all of the transformation activities recommended in the Commission report, establish specific timelines and milestones for accomplishing each objective, and report on both progress and outcomes at least quarterly to VHA leadership and the governing board. Periodic evaluation of the effect of these change initiatives on internal and external stakeholders would also be appropriate.
- Clarify the roles and responsibilities of VISNs and facilities and implement a change strategy to orient staff and leaders to these new expectations. Establish effective leadership communication mechanisms to promote transparency, dialogue, and collaboration among VHACO offices and with the field.

Other Department and Agency Administrative Changes

- None required.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

Problem

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set, identical to private-sector standards, will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes for veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

Background

One of the criteria for performance excellence in health care is the measurement, analysis, and improvement of organizational performance.⁴⁵¹ Performance measurement is used to track daily operations, overall organizational performance, and progress in achieving organizational objectives and action plans. Performance measurement is also used to benchmark organizational performance against internal and external standards.

Organizational performance measurement is not the same as workforce performance management.⁴⁵² Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Workforce and Leadership Performance Management System

- VHA create a new performance management system appropriate for health care leaders, tied to health care leadership competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

⁴⁵¹ Baldrige Performance Excellence Program, 2015-2016 *Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁵² Ibid., 20.

health care delivery and the achievement of action plans.⁴⁵³ Although there is a relationship between organizational performance measurement and workforce performance management, they are not synonymous processes.

Workforce performance management is made up of much more than just clinical outcome measures. As noted by the American College of Healthcare Executives (ACHE), performance evaluations of hospital CEOs must also evaluate leadership traits such as judgment, communication, and diplomacy.⁴⁵⁴ Furthermore, ACHE emphasizes the inclusion of individual professional objectives in performance plans, such as promoting ethical behavior, supporting diversity and inclusion within the organization, or fostering effective medical staff relationships.⁴⁵⁵ ACHE and other leading practitioners⁴⁵⁶ emphasize that performance management is not a plan or an event, but rather a continuous, ongoing process and conversation among the leaders and their reviewers. A workforce performance management system must also make meaningful distinctions among individuals⁴⁵⁷ and promote high performance through rewards, recognition, and incentive practices.⁴⁵⁸ Ideally, when coupled with a leadership competency model and development program, workforce performance management should also help to identify high-performing potential leaders and provide guidance to the workforce on how to move up in the leadership ranks.⁴⁵⁹ As deployed in FY 2015 and evaluated by the *Independent Assessment Report*, VHA's performance management system failed to effectively achieve any of these objectives.⁴⁶⁰

Analysis

One of the findings in the *Independent Assessment Report* was that “hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important.” More than 300 measures spanned everything from critical clinical metrics to political priorities introduced to address the most recent crisis. VHA reports that it was tracking approximately 500 measures,

⁴⁵³ Ibid.

⁴⁵⁴ “Policy Statement: Evaluating the Performance of Hospital or Health System CEO,” November 2013 (revised), American College of Healthcare Executives, accessed February 18, 2016, <https://www.ache.org/policy/ceo-perf.cfm>.

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid. NeuroLeadership Institute’s “Reengineering Performance Management: How Companies are Evolving Beyond Ratings” webinar, scheduled on January 14, 12-1.

⁴⁵⁷ “Implementing FCAT-M Performance Management Competencies: Differentiating Performance,” Office of Personnel Management, Performance Management: Performance Management Cycle, accessed June 10, 2016, <https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/>.

⁴⁵⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization’s Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁵⁹ Office of Personnel Management. Proficiency Levels for Leadership Competencies. <https://www.opm.gov/policy-data-oversight/proficiencylevelsforleadershipcompetencies/>. “Joint Medical Executive Skills Institute,” Health.mil: The official website of the Military Health System and the Defense Health Agency, accessed June 13, 2016, <https://www.jmesa.army.mil/documents.asp>, National Center for Healthcare Leadership. NCHL Healthcare Leadership Competency Model. <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁶⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78-79, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.⁴⁶¹

Distinct from performance measurement, the performance management process⁴⁶² is a cycle that begins with clear input from top leadership on the priorities of the organization, followed by clear targets, performance tracking, reviews, and rewards. The *Independent Assessment Report* noted that, “Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards.”⁴⁶³ Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,⁴⁶⁴ metrics are hard to track in real time and lack the detail required for individual performance assessment,⁴⁶⁵ and few plans are written to support shared accountability and team-based solutions. In addition, participants observed that the current senior executive performance agreements and rating process (a) do not result in meaningful distinctions in performance between individuals, (b) do not drive meaningful conversations about individual performance, (c) and do not consistently focus on key health care metrics of quality, safety, patient experience, operational efficiency, finance, and human resources.⁴⁶⁶ The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.⁴⁶⁷

Information provided to the Commission indicates that VHA has taken action to address some of these findings. First, the USH has reestablished a performance accountability workgroup (absent for a number of years) comprising leaders from the field and VHACO to provide oversight and direction to the performance measurement process.⁴⁶⁸ The workgroup has been charged with aligning metrics to each level of VHA, dramatically simplifying metrics, and increasing the capacity of the organization to focus on measures that truly matter.⁴⁶⁹ The group has created an aspirational vision of a performance measurement system that describes cascading accountability from the top of the organization with health system outcomes (reported annually) through strategic measures (reported quarterly), to tactical measures (reported monthly) to transactional measures (reported in real time).⁴⁷⁰ It is critical that these aspirations become policy.

⁴⁶¹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁶² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴⁶³ Ibid., 82.

⁴⁶⁴ Ibid., 82.

⁴⁶⁵ Ibid., 84.

⁴⁶⁶ Ibid., 84.

⁴⁶⁷ Ibid., 87.

⁴⁶⁸ David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).

⁴⁶⁹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁷⁰ Ibid.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.⁴⁷¹ As a large, national health care system, internal benchmarking can be a valid method to drive change, yet both internal and external audiences may ask how well VHA performance compares to that of private-sector providers. VHA currently posts some patient quality, safety, and outcome measures on both its website and on the Department of Health and Human Services (HHS) Hospital Compare website.⁴⁷² These measures allow patients to evaluate the quality of care they receive from VA and make informed health care decisions. They include measures of timely and effective health care; measures of readmissions; complications of death, surgical complication measures and health-care related infection measures; survey data of patient experiences; and other measures required of hospitals participating in Medicare.⁴⁷³ Former USH Kizer believes this reporting is insufficient, noting

*the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to Hospital Compare and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.*⁴⁷⁴

The Commission has reviewed VHA's principal measurement approach, Strategic Analytics for Improvement and Learning Value Model (SAIL) and has determined that although it is modelled on private-sector approaches to measurement and rating, measures are not exactly the same as those reported in the private sector and consequently impede direct benchmark comparisons of VHA to the private sector. Updating these measures so they are consistent with the private sector will be especially important as integrated delivery networks are established and more care is received in the community, as they will allow for making objective comparisons.

Measurement, analysis, and improvement of organizational performance work together as a key system.⁴⁷⁵ The USH has signed a new organizational chart for VHA that acknowledges the interconnection of these elements by establishing an office for organizational excellence that encompasses all of these functions.⁴⁷⁶ To be effective, not only must all of the various units within this office work together but also they must work with personnel in the field to coach and develop their ability to effectively apply performance measurement and improve organizational performance.

⁴⁷¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation?" Ashish K. Jha, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, September 2006, accessed April 21, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation>.

⁴⁷² "Quality of Care: How Does Your Medical Center Perform?" Medical Center Performance Search (MCPS), U.S. Department of Veterans Affairs, accessed May 16, 2016, <http://www.va.gov/qualityofcare/apps/mcps-app.asp>.

⁴⁷³ Title XVIII of the Social Security Act 42 U.S.C. § 1395 et seq.

⁴⁷⁴ Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014

⁴⁷⁵ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁷⁶ See the proposed organizational chart at end of Recommendation #12.

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These improvements in performance measurement do not appear to be mirrored on the performance management side of the equation. The draft FY 2016 performance plan template for network directors and medical center directors,⁴⁷⁷ although more streamlined than in previous years, continues to reflect confusion of performance measurement and performance management. It also continues to distribute all of the organization's key (and not so key) priorities under OPM executive core qualifications of leading change, leading people, business acumen, building coalitions, and results driven. The new, streamlined performance measures described above could be considered results-driven; however, the rest of the plan continues to be a confusing presentation of instructions to field leaders, restatements of policy, and performance objectives for action plans. Only the last category is appropriate for workforce performance management.⁴⁷⁸ The Corporate Senior Executive Management Office has implemented a new online performance management data tool that allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.⁴⁷⁹

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify organizational performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem-solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.⁴⁸⁰ The Commission broadly agrees with this approach to performance measurement. In addition, the Commission emphasizes that VHA customers and stakeholders require public reporting of clinical quality measures that are the same as, and therefore directly comparable to, measures used by the private sector. Although VHA may require an enhanced set of measures that reflects services not broadly deployed in the private sector, or for which measures do not yet exist, a minimum set that are the same as private-sector measures must be used by VHA. As VHA expands integration of care with the community, the use of the same measures as the private sector will be important so that direct comparisons can be made of care delivered inside VHA and that delivered under contract or partnership agreement by the VHA community care network.

VHA also requires a cohesive, integrated personnel performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes

⁴⁷⁷ Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan Template*, Network Directors and Medical Center Director, November 20, 2015.

⁴⁷⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁷⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁴⁸⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 81, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

accountability to key organizational outcomes; but also assesses organizational and professional objectives. A new personnel performance management system must be free of OPM requirements for executive core qualification and certification process and instead be benchmarked to the private sector⁴⁸¹ and consistent with the new leadership competency model. Congress required DoD to establish independent competency standards for the Commanders of Military Treatment Facilities (MTFs) and should consider doing the same for VHA.⁴⁸² This new performance management model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with current perceptions of the rating scales, it would be helpful to establish a new rating scale for the performance management system. Once the new system is developed, VHA must conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must also address the responsibilities of the rater. This includes clearly establishing written performance requirements for subordinates that are both timely (i.e., prior to the start of the rating period) and meaningful. Raters must be required to provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The CVCS must establish this expectation by clearly communicating what is required of raters, and most importantly, by modeling the behavior. Finally, raters must provide meaningful ratings that distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings for which the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching or, if justified, sanctioned.⁴⁸³ To accomplish the last point, raters themselves must be given feedback and oversight to understand how their approach to rating compares to other leaders in the organization. If raters' assessments are not consistent with rating standards, their supervisor must bring this issue to their attention and include it in the performance assessment they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written performance plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to raters. Final ratings and a comparison of raters can be conducted and provided to all of the executive raters in the organization. Finally, such a tool can also be used to identify and track high performers who deserve further investment and development as leaders from VHA.

⁴⁸¹ The American College of Healthcare Executives, *2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. "NCHL Health Leadership Competency Model™," National Center for Healthcare Leadership, accessed May 16, 2016 <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁸² Department of Defense Appropriations Act of 1999, Pub. L. No 105-262, Section 8052 (1998): "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

⁴⁸³ Delos M. (Toby) Cosgrove, MD, CEO, Cleveland Clinic, statement during Commission on Care public meeting, March 22, 2016.

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Implementation

Legislative Change

- Obtain legislative relief from the requirement to use the OPM executive core qualifications system of competencies and ratings and tied to new Title 38 pay authority for health care leaders (see Recommendation #15).

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Establish a workgroup and engage outside experts to create a new performance management system for VHA leaders that is appropriate for health care executives.
- Establish standards and processes to hold raters accountable for creating meaningful distinctions in performance between subordinate leaders.
- The new Office for Organizational Excellence should work with experts to reorganize their internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Other Department and Agency Administrative Changes

- None required.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

Problem

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans, and must become a strategic priority throughout the organization, because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veteran's care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Background

Cultural competence is the ability of health care organizations and their providers to understand and respond effectively to the cultural, language, and in VA's case, military service experience brought by the patient to the health care encounter. It has been endorsed as a viable skill set to reduce, if not eliminate, the rate at which health care disparities occur. VHA has recognized the problem of health disparities among its patient population and has taken steps to address it by tasking certain internal offices with building cultural and military competence throughout the organization. For example, VHA established the Office of Health Equity (OHE) and charged it with championing the efforts to identify, understand, and address health care disparities among veterans.

Analysis

There are seven essential strategies for promoting and sustaining organizational and systemic cultural competence. These strategies include the following:⁴⁸⁴

- Provide executive-level support and accountability.
- Foster patient, community, and stakeholder participation and partnerships.
- Conduct organizational cultural competence assessments.
- Develop incremental and realistic cultural competence action plans.

⁴⁸⁴ Miriam E. Delphin-Rittmon et al., "Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence," *Psychiatric Quarterly*, 84, (2013), 53-64.

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- Ensure linguistic competence.
- Diversify, develop, and retain a culturally competent workforce.
- Develop an agency strategy for managing staff and patient grievances.

VA has taken some steps to address cultural and military competence strategies, but these programs are not sufficient to address the breadth and depth of the problem. These strategies will not take hold and become fully ingrained in VHA's culture unless VHA leadership makes them a key priority and commits the resources and on-going, comprehensive training required to build cultural competencies across the entire VHA workforce.

Military Competency

In addition to addressing the needs of minority veterans and vulnerable veterans populations, VA must address military-specific needs and ensure that all providers in the VHA Care System have sufficient military competency (i.e., knowledge of specific issues and health care needs of those who served in the military). VHA's Office of Academic Affiliations developed a *Clinician Pocket Card* for providers that includes questions for clinicians to ask veterans about their military health history.⁴⁸⁵ The *Pocket Card* and similar resources should be given to all VHA and community providers to leverage during veteran patient medical assessments and appointments. In addition, VA's Office of Public Health (OPH) provides information on VA health care programs for veterans who were exposed to environmental and occupational hazards during military service, such as Agent Orange, chemicals leading to Gulf War veterans' illnesses, and Camp Lejeune water contamination.⁴⁸⁶ This military exposure information should be leveraged in VA's cultural competency strategy.

Health care disparities often result from patients' lack of trust in their health care provider; therefore, enhancing the patient-provider relationship is paramount in overcoming these disparities. Stereotypical thinking on the part of providers about certain patient groups, including veterans, may unwittingly influence their prognosis.⁴⁸⁷ Specific reasons for the increase of health care disparities in the military population include the following:

- the cultural norms of the military are such that to admit or display any signs of perceived weakness, especially related to mental health issues, discourages military personnel and veterans from seeking medical care and treatment
- changes in the demographical makeup of the civilian population result in similar changes to the military population
- a small but gradual increase in the number of foreign born personnel who have joined the ranks of the military

⁴⁸⁵ Department of Veterans Affairs, Office of Academic Affiliations, *Military Health History: Pocket Card for Health Professions Trainees and Clinicians*, accessed June 12, 2016, <http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf>.

⁴⁸⁶ "Public Health: Military Exposures," U.S. Department of Veterans Affairs Intranet, accessed June 12, 2016, <http://vaww.publichealth.va.gov/exposures/index.asp>

⁴⁸⁷ G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," JHHSA (2011), 148.

- a disengaged provider culture that may have become more immersed in the medical culture than the military culture

VA must make cultural and military competence a strategic priority, provide the resources needed to execute the strategy, and hold leadership and providers, both within VHA and community partners, accountable for strategy implementation and integration into VA's culture.

Women

Women are the fastest growing group within the veteran population.⁴⁸⁸ As of 2011, approximately 1.8 million (8 percent) of the 22.2 million veterans were women. Data indicate that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. As the number of women veterans increases, VHA continues to prepare for an increasing demand for women veterans' health care needs.⁴⁸⁹ To address the health disparities affecting women veterans, VHA must provide high-quality, equitable care on par with that of men, deliver that care in a safe and healing environment, provide seamless coordination of services, and actively recognize women as veterans.⁴⁹⁰

In the past, VHA found gaps in its ability to provide comprehensive primary care for women veterans because many primary care providers had little or no exposure to women patients and women were often referred outside of primary care for gender-specific care. To close these gaps, VHA has implemented women's health comprehensive primary care clinic models with the goal of providing complete primary care from one designated women's health provider (DWHP) at one site. An analysis of FY 2012 data revealed that women assigned to DWHPs had more positive overall experiences with care and were more satisfied on six composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.⁴⁹¹ VA has substantially reduced gender gaps in care,⁴⁹² but women veterans still encounter challenges when accessing care. VHA leadership must support the future planning of women's services and programming so that women veterans receive the highest quality health.⁴⁹³

LGBT Equity

In its systemwide implementation of cultural competency, VHA should leverage best practices from an area in which the agency is already an equity leader: treatment of LGBT patients. Every year since 2007, the Human Rights Campaign has published a Health Equality Index (HEI) report that aims to measure the quality of health care for LGBT patients based on core criteria

⁴⁸⁸ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

⁴⁸⁹ U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, April 2015, accessed June 12, 2016, http://www.womenshealth.va.gov/WOMENSHEALTH/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

⁴⁹⁰ Patricia M. Hayes, Chief Consultant Women's Health Services, VHA Office of Patient Services, briefing to the Commission on Care, October 19, 2015.

⁴⁹¹ Ibid.

⁴⁹² Ibid.

⁴⁹³ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

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that require health care systems to couple strong policies with appropriate training.⁴⁹⁴ In 2016, VAMCs made up 20 percent of all HEI participants. Among participating VAMCs, 84 percent were designated with *Leader* status.⁴⁹⁵ VHA hospitals publicize that discrimination against LGBT patients and employees is prohibited. Senior managers are registered for HEI training. And equal visitation rights are granted to families and friends of LGBT patients. VHA hospitals play a critical role in promoting patient care equality in states where VHA is the only Equality Leader.⁴⁹⁶ VHA should create strong policies and mandatory training, like that used to promote health equity for LGBT patients, to address equity issues for racial and ethnic minorities and women.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- VHA Care System providers should be required to ask patients about their military health history and incorporate veterans' responses into patients' treatment plans.
- VHA leadership should support the future planning of women's services and programming so that women veterans receive the highest quality health care.
- VHA should leverage the best practices developed in support of LGBT equity and implement them across VHA.
- VHA Care System providers should be required to attend comprehensive, on-going cultural and military competency training.

Other Department and Agency Administrative Changes

- None required.

⁴⁹⁴ "How the VA is leading the way on LGBT patient care," Andrew Park, *The Week*, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

⁴⁹⁵ "Office of Health Equity: Healthcare Equality Index," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/HEALTHYEQUITY/Healthcare_Equality_Index.asp

⁴⁹⁶ "How the VA is leading the way on LGBT patient care," Andrew Park, *The Week*, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-v-a-leading-way-lgbt-patient-care>.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Problem

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

Background

During the 1990s, Congress passed the Government Performance and Results Act⁴⁹⁷ to correct shortcomings in the way government was managed and assessed in an effort to bring modern business management practices into the federal government. The law was updated in 2011,⁴⁹⁸ yet one essential

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.
 - Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

⁴⁹⁷ Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).

⁴⁹⁸ GPRA Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (2011).

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component of modernizing the management of federal programs is still missing: reform of human capital management.⁴⁹⁹

The Civil Service Act was initially passed in 1883 and revised in 1978.⁵⁰⁰ The *general schedule*, which governs the pay and job classification process, was codified by regulation in 1949. The U.S. workforce, including the federal workforce, has changed dramatically since these laws and regulations were implemented. As noted in a recent report from the Partnership for Public Service, “the personnel system, designed more than 60 years ago, now governs more than 2 million workers and is a relic of a bygone era, reflecting a time when most federal jobs were clerical and required few specialized skills.”⁵⁰¹ As of 2013, nearly two-thirds of federal employees work in professional or administrative positions focused on knowledge-based work, with the Department of Veterans Affairs accounting for the largest percentage of such workers.⁵⁰²

The Partnership for Public Service calls for broad reform of the civil service system, noting that the

*the federal workforce has become an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission critical. . . . Federal employee pay . . . is not tied to the broader labor market, making it harder to compete with the private sector for talent. That disconnect is exacerbated by a job classification system that describes a workplace from the last century.*⁵⁰³

This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.⁵⁰⁴ The unnecessarily complex hiring system is difficult for applicants to navigate and makes it challenging for hiring managers to identify the most qualified candidates, hindering the ability to bring in experienced candidates from the private sector.⁵⁰⁵

*The civil service system has become a maze of rules and procedures that are not perceived as rational by the people who serve in government or by the general public. . . . Rigid policies . . . are now a burden on a government that needs to encourage flexibility and innovation to meet rapidly changing and difficult challenges.*⁵⁰⁶

⁴⁹⁹ U.S. General Accountability Office, Office of the Comptroller General, *Human Capital – A Self-Assessment Checklist for Agency Leaders*, accessed April 11, 2016, <http://www.gao.gov/assets/80/76520.pdf>. U.S. General Accountability Office, *Transforming the Civil Service: Building the Workforce of the Future – Results of a GAO Sponsored Symposium*, accessed April 11, 2016, <http://www.gao.gov/assets/200/197256.pdf>.

⁵⁰⁰ The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).

⁵⁰¹ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰² Ibid. The Department of Defense in total has more knowledge workers but the numbers for each service are reported independently and are below the total for the VA workforce.

⁵⁰³ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰⁴ Ibid.

⁵⁰⁵ Ibid.

⁵⁰⁶ Ibid.

The General Accounting Office (GAO) also continues to point to human capital management as a high-risk area across government.⁵⁰⁷ DoD has proposed walking away from the Title 5 civil service system to support modernization of human capital management,⁵⁰⁸ President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service,⁵⁰⁹ and Congress is considering whether the time is right for civil service reform.⁵¹⁰

VHA currently uses three different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and other, mostly nonclinical, employees; Title 38 for physicians, dentists, and other specified health care professionals;⁵⁰⁹ and Title 38 Hybrid for allied health professionals such as pharmacists and licensed physical therapists.⁵¹⁰ Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.⁵¹³ Currently, about two-thirds of VHA employees serve in the Title 38 Hybrid occupations.⁵¹⁴

VHA is not alone in having an excepted service system. More than a dozen agencies have special legislative authority to create a personnel system to fit their particular needs, including the Federal Bureau of Investigation, National Institutes of Health, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and National Aeronautics and Space Administration.⁵¹¹ In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also instituted governmentwide direct hiring authority for difficult-to-recruit positions, including medical officer, nurse, pharmacist, radiologic technician, and information technologist – all positions critically important to VHA’s mission success.

Modernizing human capital management is a global imperative for the private sector as well, with 92 percent of participants in one assessment of 7,000 businesses noting that a new approach to human resources is a critical organizational priority in 2016.⁵¹² According to a report from Deloitte, which examined broad human resource (HR) trends, “HR is redesigning almost everything it does – from recruiting to performance management to onboarding to reward systems” to learning and development.⁵¹³ Younger workers are driving many of these

⁵⁰⁷ U.S. GAO, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce U.S. Postal Service and the Census, Committee on Oversight and Government Reform, House of Representatives, Statement of Robert Goldenkoff*, GAO-14-723T, July 15, 2014, Washington, DC, 2014, accessed June 12, 2016, <http://www.gao.gov/assets/670/664772.pdf>.

⁵⁰⁸ “Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System,” Jared Serbu, Federal News Radio, accessed April 8, 2016, <http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/>.

⁵⁰⁹ “Obama’s Budget Touts Progress Within Federal Workforce, but Offers It Nothing New,” Eric Katz, Government Executive, accessed April 8, 2016, <http://www.govexec.com/management/2016/02/obamas-budget-touts-progress-within-federal-workforce-offers-it-nothing-new/125815/>. The Office of Management and Budget, *Fiscal Year 2016 Budget of the U.S. Government*, accessed May 13, 2016, <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf>.

⁵⁰⁹ “Brace Yourselves: Congress Preps Civil Service Reform,” Andy Medici, Federal Times, accessed April 8, 2016, <http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/>.

⁵¹⁰ Ibid.

⁵¹¹ See, e.g., 38 U.S.C. § 7401(1).

⁵¹² See, e.g., 38 U.S.C. § 7401(3).

⁵¹³ Joleen Clark, Jack Hetrick, and Donna Schroeder, “Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers,” Alternative Personnel System (2014).

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changes with expectations for meaningful work, learning opportunities, and career progression.⁵¹⁴ These workers have been choosing the federal government in diminishing numbers, with only 6 percent of federal employees currently younger than 30 years of age (compared to 23 percent of the civilian workforce).⁵¹⁵ In VHA, millennials (those 34 and younger) make up only 15 percent of the workforce, but are disproportionately over-represented among staff that quit VHA, at 20 percent.⁵¹⁶

As of January 2016, VHA had a vacancy rate of 16 percent for all positions, despite filling more than 40,000 positions in FY 2015.⁵¹⁷ VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.⁵¹⁸ This problem occurs in the face of acknowledged national shortages of physicians⁵¹⁹ and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.⁵²⁰ Taken together, this information makes clear that excellence in human capital management continues to be a business imperative for VHA.

Analysis

The human resource function within VHA needs a fundamental overhaul to increase responsiveness, efficiency, and customer service, as well as to align its orientation to the business needs of VHA.⁵²¹ Medical center directors do not receive the support they need from HR to accomplish hiring, disciplining, and planning for succession of employees.⁵²² During exit interviews, staff members who leave VHA cite barriers to career growth, insufficient professional development, a lack of promotions, and poor on-boarding and training as reasons for departing.⁵²³ In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career

⁵¹⁴ U.S. GAO, *The Excepted Service: A Research Profile*, GAO/GGD-97-92, accessed April 12, 2016, <http://www.gao.gov/assets/80/79968.pdf>.

⁵¹⁵ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 12, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵¹⁶ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

⁵¹⁷ “VA Struggles to Fill Medical Center Positions in Arizona, Across Nation,” Danika Worthington, Arizona Daily Sun, accessed April 5, 2016, http://azdailysun.com/news/local/va-struggles-to-fill-medical-center-positions-in-arizona-across/article_a14e6937-ecc1-5415-9391-7a6d759e5025.html.

⁵¹⁸ Joleen Clark, Jack Hetrick, and Donna Schroeder, *Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers*, *Alternative Personnel System* (2014).

⁵¹⁹ IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013-2025*, accessed April 12, 2016, <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>.

⁵²⁰ “Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,” U.S. Department of Health and Human Services, Health Resources and Services Administration, accessed April 12, 2016, <http://www.hrsa.gov/shortage/>.

⁵²¹ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, x, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²² Ibid., vii.

⁵²³ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.⁵²⁴

The Civil Service System Does Not Support a High-Performing Health System.

Recruitment in VHA operates in an incredibly complex environment. Federal rules and regulations make HR more challenging than it is in the private sector.⁵²⁵ For example, interviews in 2014 with more than 500 VHA hiring managers and HR staff members pointed to the top problems with Title 5 recruitments as OPM classification standards, grading of position descriptions, position characterization, and the ranking and rating process.⁵²⁶ The group specifically noted that there are many staff positions required in a health care delivery system that do not translate into a general schedule occupational series; therefore, when the positions are graded, the grade and salary is too low to compete with the private sector. Examples of such positions are custodial workers (hospital employees need to apply antiseptic cleaning techniques, but general custodians do not) and general facilities and equipment maintenance (hospital employees need to understand the maintenance of such items as specialized medical equipment, positive pressure rooms, and sterile plumbing systems that are not requirements for general plant maintenance at an office building).⁵²⁷ In another example, VHA managers noted that the OPM classification standard for supply chain positions rendered VHA unable to compete for local talent because the assigned grade was too low.⁵²⁸

The general schedule system also has been identified as a barrier to career advancement.⁵²⁹ Clerical staff members in particular often cannot advance in pay and responsibility without leaving their positions and moving into a different job series.⁵³⁰ Similarly, frontline customer service staff under the general schedule cannot receive advanced steps within the grade for better performance or completing job-related certifications or degrees, unlike nurses and allied health professionals who can receive advances in pay for these accomplishments.⁵³¹

The hiring process in VHA is acknowledged to take too long.⁵³² “HR is expected to fill a position within 60 calendar days . . . but process requirements, even if perfectly executed, take about 49

⁵²⁴ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵²⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²⁶ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014.

⁵²⁷ Veterans Health Administration, “Leading Access Scheduling Initiative – People, Assessment of Hiring Barriers,” VHA Classification Workgroup, 2014.

⁵²⁸ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xiii, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

⁵²⁹ Ibid.

⁵³⁰ “Classification and Qualification: Classifying General Schedule Positions,” U.S. Office of Personnel Management, accessed November 24, 2015, <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/>.

⁵³¹ Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).

⁵³² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

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to 62 days.” Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.⁵³³

This finding was echoed in a Northern Virginia Technology Council report on information technology challenges in VA that indicated across the board hiring of needed staff proceeds too slowly. “The causes are complex, but much of the delay can be traced to redundant, inconsistent, and inefficient hiring processes.”⁵³⁴ One driver of extended VHA hiring times is the government background checks and the licensing and credential review for clinical staff that is managed through VetPro, an internet-enabled data bank for credentialing VHA personnel.⁵³⁵

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA’s workforce.⁵³⁶ An internal VHA workgroup that examined HR concluded that a complete break with Title 5 and a reworking of current Title 38 hiring authority is required, stating:

*The existing Personnel system does not meet today’s market or demand. With VHA’s tremendous volume of occupations to hire and significant turn-over rate in critical positions, it is necessary to promote an efficient organizational system to be able to hire qualified candidates as quickly as possible. The current classification system led to disparity across the systems and only looks at the duties of the position versus the qualifications of the person. The VHA hiring system must be agile and attractive to recruit those that just graduated or are entering the workforce... An agency specific excepted employment system would allow VHA to meet the unique staffing demands that are required of a complex health care organization.*⁵³⁷

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite a generous benefits package and the possible opportunities for greater work-life balance, and for research and teaching in a system that serves the important role of caring for the nation’s veterans, lower salaries reduce VHA’s competitive edge in the marketplace when trying to attract top talent.⁵³⁸ For example, although VHA is often able to provide physicians an entry salary that is comparable or better than industry standards, physicians’ long-term earning potential is dramatically less in VHA than that of their private-sector peers. “At the top of the salary ranges, VHA providers made less than their counter parts

⁵³³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow-Clinical)*, 45-49, accessed May 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁵³⁴ Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America’s Veterans*, 12, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

⁵³⁵ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 37, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵³⁶ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵³⁷ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵³⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 39, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

by up to \$310,000 and on average, \$74,631. The only specialties for which VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry.”⁵³⁹ In another example of barriers to competitive pay, current provisions in law limit VA to a 60 percent level of market pay compensation for allied health professionals, even when recruitment failures demonstrate the need to offer higher salaries.⁵⁴⁰ As noted above in the discussion on classification, failure to appropriately classify positions also leads to a salary that is not competitive with private-sector health care organizations for positions such as customer service personnel.

In the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas.⁵⁴¹ VHA can offer up to a maximum of \$60,000 for 2 years (\$30,000 per year). HRSA National Health Service Corps (NHSC) runs three programs: the NHSC loan repayment program that provides up to \$50,000 in loan payments, the Student-to-Student Loan Repayment Program for up to \$120,000, and the State Loan Repayment Program with each state establishing loan amounts that are administered by HRSA.⁵⁴² These amounts range broadly from \$80,000 in Arizona and Arkansas, \$90,000 in Colorado, \$100,000 in Georgia and Alabama, and \$190,000 in California.⁵⁴³

Clinic Staffing Is Impaired by Current Law, Regulation, and Policy

Successfully reallocating staff to meet veterans’ needs in a rapidly evolving health care environment is difficult in VHA. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.⁵⁴⁴ VA policy currently prohibits full-time VA physicians from receiving fee-basis compensation from the same VA facility in which they are salaried, although they can, under certain circumstances, receive fee-basis appointments at other VA facilities.⁵⁴⁵

These restrictions can make it hard to meet policy requirements for night and weekend schedules⁵⁴⁶ without reducing staffing on inpatient units or under-resourced primary care clinics. Use of alternative work schedules and overtime pay for physicians to meet local patient demands should be under control of local medical center directors.

⁵³⁹ Ibid., 40.

⁵⁴⁰ Increases in Rates of Basic Pay, 38 U.S.C. § 7455.

⁵⁴¹ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵⁴² “Loan Repayment Program,” U.S. Department of Health and Human Services, National Health Service Corps, accessed June 9, 2016, <http://nhsc.hrsa.gov/loanrepayment/>.

⁵⁴³ “Physician Loan Repayment Guide,” Jimmy Karnezis, accessed April 13, 2016, <https://www.credible.com/blog/physician-loan-repayment-guide/>.

⁵⁴⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 136, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁴⁵ VA Handbook 5005, pt. II, ch. 3, § A, para. 3b.

⁵⁴⁶ Extended Hours Access for Veterans Requiring Primary Care Including Women’s Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, VHA Directive 2013-001 (2013).

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VHA Staff Receive Inadequate Training Including at Initial Hire

Leading practices include providing mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, “Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company’s culture and values, its goals and history and its power structure.”⁵⁴⁷ To make up for inadequate on-boarding and to fill current staff’s understanding of VA, VHA is providing VA 101 training for current employees, with 60 facilities having completed the training in FY 2015.⁵⁴⁸ Employees in VA continue to desire a wide array of training, including customer service training, professional development, peer-to-peer training, hands-on training, and role-specific training.⁵⁴⁹

HR Professionals Must Focus on People and Business Priorities Not Compliance

VHA job candidates indicate they have unsatisfactory recruiting experiences, noting failures in timely follow-up and communication.⁵⁵⁰ VA human resources management and administration indicate that VA HR professionals do not exhibit a uniform level of competency, frequently do not understand the employee recruitment process end-to-end, and fail to provide high quality consultative support to managers with respect to all HR functions, but particularly in the area of progressive discipline and firing of employees.⁵⁵¹ Currently HR professionals in VA are largely focused on compliance with a complex set of rules,⁵⁵² rather than adding true value to the organization and being able to be full partners in accomplishing VHA business objectives. Resolving these staffing issues would render the overall HR function more effective.

VHA must become the employer of choice to attract and retain the very best health care workforce. To help it accomplish this goal, VHA requires competitive pay and flexible hiring and talent management processes. VHA cannot achieve that goal within its current personnel systems. A uniform alternative personnel system under Title 38 for all VHA human capital management would accomplish all of the following:

- Meet the unique staffing demands of a health care delivery organization.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job. VHA must consider total compensation (with benefits), as compared to market rates because the government provides many more benefits than private-sector organizations. Consequently, VA may

⁵⁴⁷Talya Bauer, Society for Human Resource Management, *Onboarding New Employees: Maximizing Success*, 2010, 9-10, accessed May 13, 2016, <https://www.shrm.org/about/foundation/products/documents/onboarding-percent20epg-percent20final.pdf>.

⁵⁴⁸ Veterans Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, presented to the National Leadership Committee, March 22, 2016.

⁵⁴⁹ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵⁵⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁵² Ibid.

pay less than private-sector employers for a position, but the total compensation (with benefits) may end up being equivalent to private-sector total compensation.

- Allow flexibility in the processes used to hire staff including direct hiring when needed.
- Support career planning and professional development through the application of competency models and training specific for health care as part of position management.
- Simplify the management tasks for supervisors and hiring managers who will only need to know one set of rules and processes instead of four.
- Simplify the job of HR professionals who will only need to know one set of rules and processes instead of four.
- Allow development and training of the HR workforce in VHA to focus on only one personnel system to create true end-to-end hiring expertise.
- Reduce competition within government where shortages of HR professionals create competition for Title 5 trained HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff in sick leave, vacation pay, salary, awards and bonuses, and compensatory time off.
- Support flow of staff between the field and VHA Central Office (VHACO) under a single personnel system.

Establishing a new human capital management system in VHA will neither be easy nor quick, nor will it be a panacea that alone will fix all that is wrong with recruitment, retention, development, and advancement. In designing and implementing a new system, VHA must take full advantage of private-sector resources and expertise in human resource management and ensure that the new system is built to be compatible with the private-sector. As VHA moves toward greater integration of care delivery, with networks of community providers, compatibility in personnel systems and a resulting greater flow of employees between VHA and community sites can help create closer linkages between the two parts of the care delivery system.

Implementation

Legislative Changes

- Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Update student loan reimbursement limits to be competitive with other federally administered programs and market conditions.

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- Establish an appeals process that provides staff appropriate due process that is based on the regulatory standards for the new alternative personnel system.

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- Eliminate barriers to creating hiring pools for positions with frequent turnover (e.g., extend the length of time over which candidates can continue to be hired from a completed certification until all of the qualified candidates are hired or have declined offers).
- Eliminate barriers to initiating a recruitment process when vacancies are anticipated; positions need not be empty before recruitment ensues. In some cases, hires should also be made before the departure of key personnel to allow for on-the-job training and mentoring of the replacement.
- Benchmark credentialing to private-sector processes and consider outsourcing the process as much as practicable through centralized mechanisms.
- Release market pay and total compensation information to the field for all job categories using commercially available data and information, at least every 2 years.

Other Department and Agency Administrative Changes

- OPM should continue to oversee and administer benefits for VHA but not impose any of the other existing conditions or requirements on the management of the new alternative personnel system. The new personnel system should be governed by the new legislative requirements and those established during the anticipated rulemaking process in VA. These requirements include market-based pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Problem

Effective planning for and management of human capital are core enabling requirements for any organization. If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

Background

As recognized by GAO, “to attain the highest level of performance and accountability, federal agencies depend on three enablers: people, process, and technology. The most important of these is people, because an agency’s people define its character and its capacity to perform.”⁵⁵³ Human capital management, although often viewed as a cost, must be viewed as an investment in business success.⁵⁵⁴ For too long, VA human capital management has been undervalued and under resourced. A 1993 report from GAO outlined many of the same deficiencies found in 2016: a focus on compliance instead of outcomes, a lack of proactive human capital planning and management, and a weak system of rewards and incentives to attract and retain qualified personnel.⁵⁵⁵

Today, VA Human Resources and Administration (HRA) shares responsibility for human capital management with VHA. Neither organization has been able to establish a high-performing, effective, human capital management system. For VHA to transform to a high-performing organization, human capital management must do the same.

Analysis

VA “needs a fundamental overhaul of the core support functions (including human resources) . . . to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation’s entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the CVCS.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

⁵⁵³ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 3, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

⁵⁵⁴ Ibid.

⁵⁵⁵ U.S. General Accountability Office, *Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals*, GAO/HRD-93-10, March 1993, accessed June 10, 2016, <http://www.gao.gov/assets/220/217512.pdf>.

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Veterans.”⁵⁵⁶ Governance and responsibility for human capital management is fragmented and complicated.⁵⁵⁷ Medical center directors appear to be largely on their own in addressing human capital management needs, without competent and timely assistance to support hiring employees, planning for succession, and taking disciplinary actions.⁵⁵⁸ Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.⁵⁵⁹ Candidates are not treated with respect, experience lengthy intervals between contacts from VA, fail to receive timely follow-up once candidates are selected, and experience a lengthy on-boarding process.⁵⁶⁰ Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.⁵⁶¹ Insufficient resources are devoted to training,⁵⁶² leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and more focused on customer service.⁵⁶³ Transforming HR will require “redesigning key processes, shifting the mindset of [human resources] staff from compliance to effectiveness, training [human resources] and its customers on key roles and responsibilities, and rationalizing its technology systems.”⁵⁶⁴

Some progress has been made in updating human capital management functions. VA is in the process of implementing new talent management software to provide better process management and analytics.⁵⁶⁵ HRA has also started a new HR Academy.⁵⁶⁶ The academy is intended to demonstrate alignment between training resources and competency requirements⁵⁶⁷ and to describe the experience needed to advance to the next position level in human resources.⁵⁶⁸ VA instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of

⁵⁵⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L3, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁶⁰ *Ibid.*, 110.

⁵⁶¹ *Ibid.*, 61.

⁵⁶² *Ibid.*, 67.

⁵⁶³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L5, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ Department of Veterans Affairs, HR Academy, *TMS User eIDP Checklist*, accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUserIDPChecklist.pdf.

⁵⁶⁸ “VA HR Academy: Resources,” Department of Veterans Affairs, accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Department of Veterans Affairs, *VA HR Competency Model Reference Guide*, accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.

performance outcomes;⁵⁶⁹ however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work.⁵⁷⁰ Although some new systems have been purchased, life cycle funding for them is not guaranteed by the Office of Information and Technology and no concrete plan has been approved to replace and consolidate the many current systems that are not interoperable. In addition, funding support for HRA initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation.⁵⁷¹

A VHA workgroup was formed with HR subject matter experts and leadership to identify hiring barriers and develop recommendations for improvements. The workgroup fielded a survey in July 2014 to gather broad input from VHA on the deficiencies in the management of human capital in VHA. These experts concluded that VHA should move to a new alternative personnel system under Title 38.⁵⁷² (See Recommendation #15.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support the departments' human capital management does not support long-range planning and effective program implementation. The lines of authority and management for human capital management professionals do not permit consistency in the quality and skill of the human capital management professionals hired and promoted, nor does the reporting structure allow HRA to hold human capital management staff accountable for effective service delivery. The investment in human capital management information technology systems has been inadequate for decades.⁵⁷³

Top leadership, including the SECVA, DEPSECVA, and CVCS, must make the transformation of human resources a top priority as demonstrated by investing their personal time in human capital management transformation; reviewing and endorsing a transformation plan including the funding required to accomplish it; receiving regular progress updates; and engaging in problem-solving sessions with human capital management leaders to refine and advance transformation efforts. Top leadership must demonstrate to other leaders that human capital management transformation is an organizational priority by disseminating clear goals for transformation in planning documents, communicating expectations for change that are clear to all key employees, and sharing successes with subordinate leaders and employees. The CVCS must ensure that the executive who leads the human capital management function has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested organization chart in Recommendation #12.)

⁵⁶⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 24, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁷¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷² Ibid.

⁵⁷³ Ibid.

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The SECVA, DEPSECVA, and CVCS must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have informed the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the CVCS for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

The VA HRA and VHA Workforce Management Office must engage change management experts to undertake a review of human resource business processes, management structures, funding, and technology needs to create a transformation agenda and human capital management plan. As VHA is shifting to a new alternative personnel system under Title 38, the human capital management plan should consolidate in VHA the HR functions, responsibility, and authority required to hire, manage, develop, reward, and discipline staff and consider whether functions such as benefit management remain with HRA or move to VHA. Furthermore, the plan should address all of the following issues:

- need for a chief of talent management
- consistency with benchmark standards of private-sector health care systems
- key organizational structures and roles and responsibilities of VA and VHA in human capital management that are clearly defined and consistent with benchmark organizations
- the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline), which should be supported effectively by human capital management and fully meet the needs of managers and staff
- federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability to provide meaningful, timely data to managing staffing, performance tracking, and accountability
- meaningful performance metrics and risk management indicators that are established for human capital management⁵⁷⁴
- funding and full-time equivalent employee staffing for human capital functions that meet private-sector benchmark standards for health care
- knowledge, skills, and ability required of human capital management professionals at each grade and within each series, which should be clearly defined, and a requirement to assess current staff, new hires, and promotions against this standard, which should include procedures for dismissal

⁵⁷⁴ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 34, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

Once completed, this analysis and draft plan must be shared widely within the department to gain feedback and input, and it must be shared with OPM, OMB, and Congress. After incorporating feedback and finalizing the plan, HRA should engage change management experts to fully implement the transformation agenda and new human capital management plan. Implementation will require funding contributions from VA and VHA that the SECVA must mandate.

HRA must develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES). This process must include clear standards, guidelines, and training for supervisors and managers on how to implement the new progressive discipline process. All managers and supervisors and human capital management professionals must complete the training, and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA must develop HR staff to be effective coaches so they can provide the coaching and support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VHA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VHA must have a technology infrastructure to actively track and manage poor performance (annual ratings and disciplinary actions) that both human capital managers and supervisors can use to keep track of issues.

The Commission notes GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016.⁵⁷⁵ The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, technology, and the legal authority needed in HR to create a transformation agenda and human capital management plan.
- Require VHA to allocate budget to fully support the change plan and ongoing HR operations.

⁵⁷⁵ Ms. Frieda Stenzel, lead investigator, U.S. Government Accountability Office, during an initial meeting with VACO HR&A about a new study being undertaken by GAO, December 18, 2015. The study is intended to 1) assess VHAs capacity to perform its workforce planning and talent management, and 2) evaluate the effectiveness of VHAs human capital functions.

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- Develop and implement an effective progressive discipline process for all staffing authorities.

Other Department and Agency Administrative Changes

- None required.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Problem

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an other-than-honorable discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

In some cases, individuals have been dismissed from military service with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury, posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

Background

Veteran status is the basis for eligibility for all VA benefits,⁵⁷⁶ and under law a veteran is a person who has met three criteria: active-duty military service (subject to specified exceptions), 2 years of continuous service, and discharge or separation from the military under conditions other than dishonorable.⁵⁷⁷ The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), OTH, bad conduct (adjudicated by a general court or special court-martial), and dishonorable.⁵⁷⁸

Congress has established specific bars to VA benefits. Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.⁵⁷⁹ VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to mean that a discharge or release because of one of the following offenses is considered to have been issued under dishonorable conditions:

(1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or

⁵⁷⁶ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁷ Veterans Benefits, 38 U.S.C. § 101(2).

⁵⁷⁸ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁹ Certain Bars to Benefits, 38 U.S.C. § 5303(a).

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spying, (3) an offense involving moral turpitude, (4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.⁵⁸⁰

Limited exceptions to those statutory and regulatory bars permit VA to award of benefits. A claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to discharge.⁵⁸¹ Benefits may be granted based on a prior period of other-than-dishonorable service for individuals with two or more periods of service.⁵⁸²

Former service members with an OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.⁵⁸³ Former service members with OTH discharges are not recognized as veterans, so they will be routinely denied treatment unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. No routine mechanism exists to trigger adjudication to determine if such a discharge is not dishonorable. In many instances, the character of an individual's discharge is predicated on behaviors that resulted from, or are linked to, behavioral health conditions that had their origin in service, yet VA regulation bars the individual from receiving benefits.⁵⁸⁴

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments in which lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise prohibit them from being eligible for the special military benefits and entitlements reserved for honorable and meritorious service.⁵⁸⁵

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.⁵⁸⁶ For example, many service members have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.⁵⁸⁷ VA regulations not only fail to account for the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service. To illustrate, commentators have identified two regulatory bars as particularly problematic: those based on moral turpitude,⁵⁸⁸ and willful and persistent misconduct.⁵⁸⁹ Neither of those two regulatory terms, which originated in 1944,⁵⁹⁰ are defined; neither provides

⁵⁸⁰ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸¹ Certain Bars to Benefits, 38 U.S.C. § 5303(b).

⁵⁸² Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁸³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁵⁸⁴ Certain Bars to Benefits, 38 U.S.C. § 5303(a). Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁵ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 12-13, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁸⁶ *Ibid.*, 13.

⁵⁸⁷ *Ibid.*

⁵⁸⁸ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁹ *Ibid.*

⁵⁹⁰ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the

criteria or examples of what is or is not covered. Both are ambiguous and susceptible to subjective judgment,⁵⁹¹ with great potential for different VA regional offices reaching different outcomes on the same facts.⁵⁹² VA officials have acknowledged that these terms are broad and imprecise,⁵⁹³ and advocates have documented the resultant disparities in VA adjudicative decisions.⁵⁹⁴

The only specific mental-health exception to the bar-to-benefits rules — that the person was insane at the time of the commission of offense⁵⁹⁵ — is very limited. VA regulations define the term *insane*, as follows:

*An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.*⁵⁹⁶

VA's Office of General Counsel (OGC), in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters for behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

*The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that '[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing' or, in a more general sense, as a mental disorder in which 'mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life.'*⁵⁹⁷

Armed Forces," *Military Law Review*, 214, Winter, (2012): 160-192, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹¹ Ibid., 164, 186.

⁵⁹² Ibid., 10, 172. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹³ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 67, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹⁴ Ibid., 68-70.

⁵⁹⁵ Characters of Discharge, 38 C.F.R. 3.12(b).

⁵⁹⁶ Determinations of Insanity, 38 C.F.R. 3.354(a).

⁵⁹⁷ "Office of General Counsel: Opinions Year 1997," U.S. Department of Veterans Affairs, accessed June 15, 2016, <http://www.va.gov/ogc/opinions/1997precedentopinions.asp>. Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, accessed June 15, 2016, <http://www.va.gov/ogc/docs/1997/Prc20-97.doc>.

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As understood by VA OGC at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,⁵⁹⁸ is a highly restrictive standard. That narrow standard is also limiting with respect to the range of symptoms that could be considered under the *insanity* exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range effectively excludes behaviors associated with a widely prevalent service-related condition, PTSD. Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,⁵⁹⁹ impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).⁶⁰⁰ Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.⁶⁰¹ Other than its *insanity* rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, disciplinary issues leading to an individual's discharge.

The following are illustrative examples of how these regulations have worked in practice:

- John, a service member with multiple deployments to Iraq and Afghanistan and 7 years of service, received an OTH discharge after self-medicating with marijuana. He was denied VA treatment for PTSD.⁶⁰²
- Tim, a rifleman with two purple hearts and four campaign ribbons for service in Vietnam, was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. He was denied service connection for PTSD because the nature of his discharge.
- Tom, a combat infantryman in the first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family,

⁵⁹⁸ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,"* accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹⁹ Deirdre MacManus et al., "Aggressive and Violent Behavior Among Military Personnel Deployed to Iraq and Afghanistan: Prevalence and Link with Deployment and Combat Exposure," *Epidemiologic Reviews*, 37, no. 1, (2015): 196-212, <http://doi.org/10.1093/epirev/mxu006>.

Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰⁰ Lisa M. James, Thad Q. Strom, and Jennie Leskela, "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI," *Military Medicine*, 179, no. 4, (2014): 357 – 363, <http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-13-00241>.

⁶⁰¹ Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰² Swords to Plowshares, presentation to Commission on Care, January 21, 2016, accessed June 25, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former service members.

but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.⁶⁰³

In short, the VA regulation used to determine whether the character of a veteran's OTH discharge is disqualifying does not take into account behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse,⁶⁰⁴ depression,⁶⁰⁵ homelessness,⁶⁰⁶ premature mortality,⁶⁰⁷ and suicide.⁶⁰⁸ Access to VA health care is vital to successful reintegration of combat-traumatized veterans into society because it provides "the only reservoir of combat PTSD expertise."⁶⁰⁹

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,⁶¹⁰ yet many former service members are reluctant to seek treatment for behavioral health problems.⁶¹¹ Those with unfavorable discharge records who finally come forward to seek medical care must not only initiate a request for a character of discharge adjudication, but be prepared to confront a lengthy process if they elect to do so.⁶¹²

⁶⁰³ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁰⁴ Kipling M. Bohnert et al., "The Association Between Substance Use Disorders and Mortality among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age, Cohort, and Mortality Type," *Drug and Alcohol Dependence*, 128, no. 1-2, (2013): 98-103, <http://www.sciencedirect.com/science/article/pii/S0376871612003328>.

⁶⁰⁵ Leo Sher, Maria Dolores Braquehais, and Miquel Casas, "Posttraumatic Stress Disorder, Depression, and Suicide in Veterans" *Cleveland Clinic Journal of Medicine*, 79, no. 2 (2012): 92-97, <http://doi.org/10.3949/ccjm.79a.11069>.

⁶⁰⁶ Eve B. Carlson et al., "Traumatic Stressor Exposure and Post-Traumatic Symptoms in Homeless Veterans," *Military Medicine*, 178, no. 9, (2013): 970-973, <http://doi.org/10.7205/MILMED-D-13-00080>.

⁶⁰⁷ Joseph A. Boscarino, "Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service," *Annals of Epidemiology*, 16, no. 4 (2005): 248-256, <http://www.sciencedirect.com/science/article/pii/S1047279705001109>.

⁶⁰⁸ Holly J. Ramsawh et al., "Risk for Suicidal Behaviors Associated with PTSD, Depression, and their Comorbidity in the U.S. Army," *Journal of Affective Disorders*, 161, no. 1, (2014): 116-122, <http://www.sciencedirect.com/science/article/pii/S0165032714001189>.

⁶⁰⁹ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 14, accessed June 20, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁶¹⁰ Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/10761674>.

⁶¹¹ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶¹² Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, 74-78, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

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Several generations of former service members were exposed to combat trauma and continue to live with the psychological wounds of war. Lack of access to treatment for those who sustained psychological wounds that went untreated and were manifest in undesirable behavior in service is concerning. Although Congress could address this concern, VA has the means to remedy the problem without congressional action by amending its own regulations. VA could afford former service members needed treatment for their conditions when they are able to establish that their health problems were incurred in service.⁶¹³ In other circumstances, when it is likely an individual could establish eligibility for VA care, current regulation permits the individual to receive the care on the basis of a tentative eligibility determination.⁶¹⁴ This regulation permits VA to provide treatment without prior adjudication of the character of discharge.

VA should revise its regulations to lift the immediate bar to health care for former service members who have an OTH discharge. VA should award tentative eligibility for health care to at least some former service members who have an OTH discharge. The criteria for awarding tentative eligibility for care could include service in a combat theater, more than a single enlistment, duration of service, or some combination thereof. This approach would allow VA to provide meaningful access to treatment without delay for those likely to be granted eligibility. For health care purposes, VA should also revise its regulations by recognizing that the severe punishment of characterizing a person's service as OTH is not justified when extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct that resulted in the OTH discharge.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Amend 38 C.F.R. 17.34 to provide for tentative eligibility determinations applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.
- Amend of 38 C.F.R. 3.12(d) to provide for recognition of extenuating circumstances that show, for purposes of health care eligibility, that service was not OTH.

Other Departments and Agency Administrative Changes

- None required.

⁶¹³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁶¹⁴ Tentative Eligibility Determinations, 38 C.F.R. 17.34.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

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- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No.104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

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Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> ▪ Veterans with VA-rated service-connected disabilities 50% or more disabling ▪ Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> ▪ Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> ▪ Veterans who are former prisoners of war ▪ Veterans awarded a Purple Heart medal ▪ Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty ▪ Veterans with VA-rated service-connected disabilities 10% or 20% disabling ▪ Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, “benefits for individuals disabled by treatment or vocational rehabilitation” ▪ Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> ▪ Veterans who are receiving aid and attendance or housebound benefits from VA ▪ Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> ▪ Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA’s and geographically (based on resident zip code) adjusted income limits ▪ Veterans receiving VA pension benefits ▪ Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> ▪ Compensable 0% service-connected veterans ▪ Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki ▪ Project 112/SHAD (shipboard hazard and defense) participants ▪ Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 ▪ Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 ▪ *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 ▪ Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> – Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. – **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> ▪ Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> ▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

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statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et. al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%20038%20USC%20101%282%292.pdf>.

⁶⁵³ H. [REDACTED] De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

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less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

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APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

This chapter presents estimates of the costs of allowing veterans access to expanded community care through integrated networks, as well as a range of other options. In the *Recommended Option*, the one chosen by the Commission and described in Recommendation #1, veterans would be eligible to receive community care for primary and standard specialty care with a referral from any primary care doctor in the VHA Care System. Special emphasis care, care provided in a distinctive fashion by VHA, is not included in community networks.

In addition to the *Recommended Option*, we considered three alternatives that are based on a similar concept of integrated networks, but which have potential costs that could vary dramatically due to differences in the openness of access to community care and the breadth of services eligible. We also estimated the costs of three options that differ in focus from the integrated network options, including options that move selected services entirely to the community, set up a premium support model, and expand access to all Priority 8 veterans. Finally, we estimated costs for two additional policies: expanding nurse navigator/care coordinator staff to help guide and coordinate veterans' care in the integrated networks of expanded community care and granting temporary eligibility for VA health care to those with other-than-honorable discharges.

Baseline Projections

We used projections from the Enrollee Health Care Projection Model (EHCPM) produced by VHA and Milliman as the baseline upon which to build our estimates. However, with the exception of the options involving premium support and an expansion of Priority 8 enrollment, we use separate analyses and not the EHCPM to derive the estimates. Costs of VA care are modeled as the product of utilization and cost per unit of care (unit cost). Utilization is dependent on both enrollment in, and reliance on, the VA health care system, total demand for health care, and other factors. Enrollment measures how many people enroll to receive VA health care, and reliance is the percentage of their medical care that enrollees receive through VA or VA-financed community care. Unit costs measure the cost of each health care service. Unit costs can be calculated for care in VA facilities, for care outside of VA facilities, or for both, depending on the scenario being estimated.

Utilization

Utilization depends on enrollment, reliance, total demand for health care, and characteristics of the health care system, such as medical technology and practice patterns. We discuss enrollment and reliance in further detail below, but overall demand for health care is similarly important. Enrollment, reliance, and overall demand each have a multiplicative effect on

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utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent (assuming new enrollees have the same characteristics as existing enrollees). Thus, it is important to consider carefully the effect of any policy change on enrollment, reliance, and overall demand for health care. Each of these factors is subject to effects by policies that make care more convenient, less expensive, or less restricted.

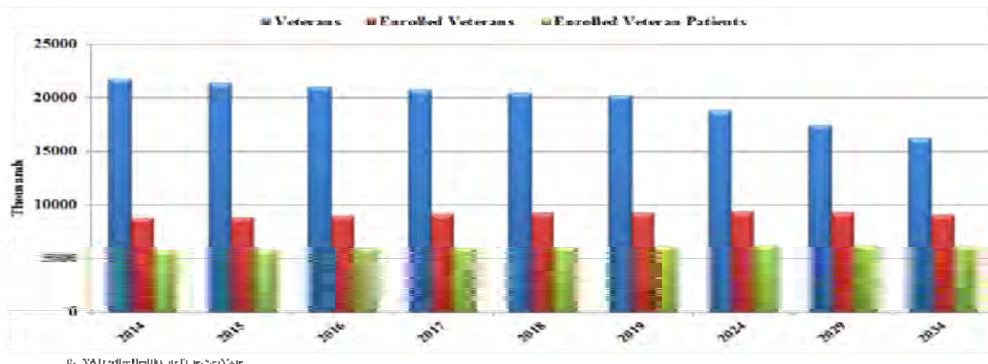
Enrollment

Currently there are 22 million veterans, 9 million of whom have enrolled and 7 million of whom are eligible to enroll but have not done so. Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death.

This enrollment trend is subject to change based on various inputs. Enrollment rates are projected based on current policy, and if policy changes, the number of enrollees and patients will change. For example, an increase in cost sharing would likely decrease enrollment and the number of patients, yet easing access to care would likely increase enrollment and the number of patients. Changes to other health insurance policies outside of VA can also affect enrollment and the number of patients (for example, changes to the Affordable Care Act).

Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period

Veterans, Enrollees, and Patients FY 2014-2034



Reliance

On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care. Many factors affect reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost-sharing levels, and characteristics of other insurance options. Any policy that affects the cost of receiving VA care, the convenience of receiving VA care, the cost or convenience of other health insurance held by enrollees, or demographic or health characteristics of enrollees, is likely to change reliance. Any increase in reliance will increase

costs to VHA, and the effect can be very large. In the absence of a policy change, VHA predicts that reliance will decline slightly from 34 percent to 32 percent during the next 20 years.

Unit Cost

Unit cost measures how much a particular service, procedure, or drug costs to provide. Unit costs can measure the cost of the unit of care in the VHA system or in the community, depending on where veterans receive care. We used unit cost projections from the EHCPM for 78 Health Care Service Categories (HSCs). The unit of measurement depends on the service. Examples include office visits, pathology procedures, vision exams, and inpatient surgical days. Unit cost projections reflect anticipated changes in price inflation and health care practice patterns, as well as historical trends. EHCPM projects separate unit costs, depending on whether veterans receive a service in a VA facility, in the community at historic Care in the Community (CITC) rates, or in the community at Medicare allowable rates. Any policy that affects the quantity of care provided in VA facilities, as opposed to the community, will have an effect on the total cost of care. If veterans receive care in the community, the rate of provider reimbursement will also affect costs.

Baseline Cost Projections

The baseline cost projections, produced by the EHCPM, show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, and other factors. The projections reflect current policy with regard to enrollment eligibility and VA health care benefits, with the exception of the *Choice Program*, which is assumed to continue for veterans living more than 40 miles away from a VA medical care facility.⁶⁶⁴

We based the projections on assumptions about inflation and anticipated effects of changes in health care practice on the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as economic recession, can occur and change projected demand for VA health care during this period. The projections do not include requirements for several activities/programs not projected by the VA EHCPM, including nonrecurring maintenance; readjustment counseling; state-based, long-term services and support programs; and some components of the CHAMPVA program.

In the absence of any policy changes, costs increase from \$53 billion in 2014 to \$125 billion in 2032. This growth is largely due to inflation and how health care practices are expected to change over time, which reflects factors that affect the cost of both VA and non-VA health care. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees will likely increase their reliance to reflect the substantially higher reliance of enrollees in the service-connected Priorities 1-3.

These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. We assume health care

⁶⁶⁴ Veterans qualifying based on wait times or excessive travel burdens are not included.

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utilization will increase or decrease at the average unit cost, when in fact it is the marginal cost that would be relevant for cost estimates. This marginal cost could be smaller or larger than the average cost, depending on existing capacity. Although we did make some assumptions about fixed and variable unit costs when care leaves VA facilities in our policy estimates below, precise estimates are not possible given data availability. Second, the EHCPM does not consider health care capacity in local communities. For these and other reasons, the EHCPM is best for the near future and for policy scenarios that do not stray dramatically from current policy. A 2008 RAND review of the EHCPM highlighted these limitations, which are particularly important for analyzing policy changes such as expanded community care.⁶⁶⁵ In light of the types of policy choices VHA is likely to consider in the future, it would be particularly beneficial for VHA to collect and incorporate the data necessary to mitigate these limitations. Due both to these limitations and to the general uncertainty regarding any long-term changes in the health care system, we suggest focusing attention on the 2019 estimates of the scenarios below, as 2019 is the first year to incorporate the fully phased-in effects of the scenarios.

Policy Estimates

In this section, we present results for the *Recommended Option* and three alternative options for expanding access to providers outside of VA through integrated networks. These options expand community care for different categories of care and vary by whether referrals are required to receive specialty care. We present estimates for several other scenarios we examined, each with a design or focus that differs from the integrated network options. Finally, we estimate costs for two other policies discussed in this report: (1) expanding the use of nurse navigators to help patients coordinate their care in VA and in the community, and (2) expanding eligibility to all veterans with an other-than-honorable (OTH) discharge until the adjudication process is complete to determine whether they will remain eligible.

Community-Delivered Services Networks

This section describes the *Recommended Option* and the first three alternative options. At least initially, all care currently provided by VA would continue to be provided by VA. In addition, expanded community care, also called Community-Delivered Services (CDS), will be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA. CDS will focus on tertiary and quaternary care, and may include primary care and all standard specialty care, depending on the scenario considered. CDS will not include special-emphasis care and some types of specialty care provided in a distinctive fashion by VHA. The network of CDS providers that VA will coordinate varies by community. To make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside VA.

The Commission's recommendation to create the VHA Care System (see p. X) considers the ways in which health plans can vary the size and scope of networks as a means of managing costs. It highlights that broad, open networks offer greater choice, but narrow, well-managed

⁶⁶⁵ Katherine M. Harris, James P. Galasso, and Christine Eibner, "Review and Evaluation of the Enrollee Health Care Projection Model," RAND Corporation, Santa Monica, CA, 2008.

networks potentially result in lower costs. It discusses ways in which, after networks are designed, VHA could exercise additional cost controls by steering patients to different providers within the networks. Finally, the recommendation regarding the VHA Care System emphasizes that access and local needs are important considerations in setting up the integrated networks, and that governance of the networks should be a process of ongoing management and evaluation.

In the estimates that follow, we assume that networks are designed and governed in a way that gives major consideration to cost, choice, and access. We assume that management of the integrated networks would be an iterative process that involves continual evaluation of resulting outcomes, including cost outcomes, and that networks would be adjusted in light of those outcomes. We also assume that local communities and services with poor access would require more community providers and/or expanded capacity within VHA than those that already have adequate access. Finally, we assume that the networks will be integrated, relatively narrow, and well-managed with the aim of controlling costs effectively. One exception is that for the *Recommended Option*, we added an estimate that assumes less-managed, broader networks to illustrate that costs are sensitive to network size and management.

Technical Assumptions for Community-Delivered Services Options

We based our estimates on utilization and unit cost data and projections for 78 HSCs that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, we projected utilization and unit costs through 2034. For HSCs that are eligible for CDS networks, we assume a certain fraction of care, depending on the option, shifts from VA facilities to the networks. We assume traditional CITC will be offered and used at baseline levels.⁶⁶⁶ We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks. All effects are phased in during the first 5 years.

Both CDS networks and CITC are priced at Medicare allowable rates by matching Medicare fee schedule data to VA HSCs.⁶⁶⁷ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities.

For care shifting into the CDS networks, we use data on the components of HSC unit costs that we obtained from the VA Allocation Resource Center. We assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. These portions, which together averaged approximately 10 percent of care in 2014, form our proxy for the portion of unit costs that VA will not be able to shed in scenarios for which, on net, care leaves VA facilities for CDS networks. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance. These costs are not part of the EHCPM, and costs and/or savings associated with changes to facilities and nonrecurring maintenance are not included in our estimates.

⁶⁶⁶ CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.

⁶⁶⁷ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

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Improving access, choice, and/or quality of services is likely to induce greater reliance and enrollment in the VA system. Although reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these increases do not represent societal costs or costs to the government. The VA budgetary cost increases may be associated with reductions in out-of-pocket expenses and improved health care benefits for patients, as well as savings to Medicare, Medicaid, and other government programs. Our cost estimates are confined solely to the VA budget.

Approximately 52 percent of eligible veterans have enrolled in VA health care, and enrolled veterans receive 34 percent of health care through VA. There is little data from which to anticipate how reliance and enrollment might change under the scenarios, and our estimates use wide ranges of assumptions for these parameters. In forming our assumptions, we consider a variety of factors, such as insurance coverage and other characteristics of eligible veterans (both enrolled and unenrolled), survey responses of veterans (both enrolled and unenrolled) on use and reasons for lack of use of VA health care, and research on take-up of health insurance coverage.⁶⁶⁸ We are confident that enrollment and reliance would increase more with greater patient choice and access. For all options, we present low, middle, and high estimates.

In addition to increases in reliance and enrollment, reduced cost sharing, increased convenience of receiving community care, and the removal of a requirement to get a referral for specialty care can increase the total amount of medical care that a patient receives. Depending on the option considered, some health care is subject to reduced cost sharing from levels typical of private insurance coverage and Medicare to the very small levels of cost sharing found in the VA system. We assume utilization increases for health care subject to lower cost sharing and/or removal of a requirement to get a referral, with our estimates based in part on the literature examining how cost sharing affects health care demand.⁶⁶⁹

Caveats

There are a number of caveats associated with all of our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for *CDS Alternative 3* and the

⁶⁶⁸ Examples of sources include: the 2014 American Community Survey; the 2010 National Survey of Veterans; the 2015 Survey of Veteran Enrollees' Health and Use of Health Care; Katherine Baicker, William J. Congdon and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *The Milbank Quarterly*, 90(1) (2012), 107-134.

⁶⁶⁹ Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," Washington, DC, 2008. Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77(3) (1987), 251-77.

same as existing enrollees in the *Recommended Option* and *CDS Alternatives 1 and 2*.⁶⁷⁰ Finally, we do not estimate any administrative costs associated with CDS networks other than the additional RN care managers hired to handle the increased clinical and administrative burden of expanded community care. These additional, nonmodeled administrative costs could be substantial.

Commission Recommended Option

The *Recommended Option* would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA or a third-party administrator. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in VA in a distinct fashion).⁶⁷¹ In 2014, 68 percent of care would have been eligible for CDS networks at current VA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network. In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and 20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was

⁶⁷⁰ Assumptions based on previous analysis by VHA and Milliman.

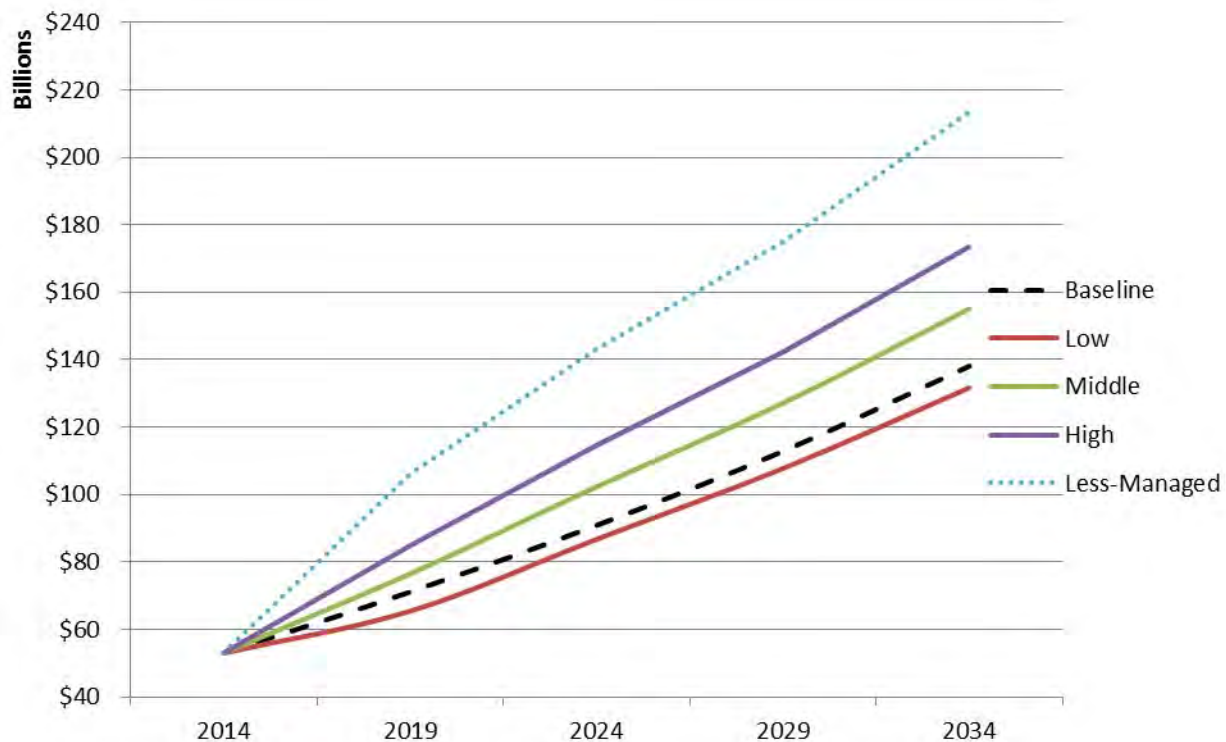
⁶⁷¹ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

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formerly subject to sizable cost sharing with private insurance or Medicare, and now it would be subject to little if any cost sharing associated with VA-financed care.

Figure A-2 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

Figure A-2. Projected Costs of Recommended Option



APPENDIX A

FINANCING THE VISION AND MODEL

COST ESTIMATES Commission on Care Scenarios							
	Brief Description	Utilization Increase	Enrollment Increase (low, middle, high)	Reliance (low, middle, high)	Cost FY 2014 Actual (billions)	Cost FY 2019 Projected (billions)	Cost FY 2034 Projected (billions)
Baseline	2014 Actual		9,078,615	34%	\$53	\$ 71	\$ 138
Recommended (low)	Referral Based Care in VHCS (68% of current VHA care eligible as CDS)	+20% of new demand in CDS Care	5%	40%	\$ 65	\$ 132	
Recommended (middle)	same	same	15%	50%	\$ 76	\$ 155	
Recommended (high)	same	same	20%	60%	\$ 85	\$ 173	
Recommended (less-managed)	same	same	50%	60%	\$ 106	\$ 213	
Alternative 1 (low)	Similar to Recommended but primary care, inpatient med and surg and some standard specialty care not eligible for CDS remain in VHA (47% of care eligible for CDS)	+20% of new demand in CDS Care	0%	10%	\$ 66	\$ 128	
Alternative 1 (middle)	same	same	5%	35%	\$ 73	\$ 140	
Alternative 1 (high)	same	same	10%	50%	\$ 78	\$ 151	
Alternative 2 (low)	Similar to Alternative 1 but primary care coordinator must only be consulted; no referral required (47% of care eligible for CDS)	+20% CDS eligible Care	5%	60%	\$ 97	\$ 191	
Alternative 2 (middle)	same	same	10%	80%	\$ 123	\$ 243	
Alternative 2 (high)	same	same	20%	100%	\$ 154	\$ 307	
Alternative 3 (low)	Similar to Alternative 2 but primary care, inpatient med/surg and specialty care eligible for CDS and no consult required	+20% CDS eligible Care	75% (level)	80%	\$ 167	\$ 320	
Alternative 3 (middle)	same	same	85% (level)	90%	\$ 206	\$ 395	
Alternative 3 (high)	same	same	95% (level)	100%	\$ 250	\$ 479	
Keep Selected Services (low)	Move most standard ambulatory specialty care to community	+20% of new demand in CDS Care	0%	10%	\$ 64	\$ 128	
Keep Selected Services (middle)	same	same	4%	25%	\$ 70	\$ 136	
Keep Selected Services (high)	same	same	8%	40%	\$ 75	\$ 145	
Premium Support	Enrollees under age 65 can choose a subsidized insurance premium with cost sharing in lieu of VHA care	42% of enrollees <65 choose premium support	6%		\$ 82	\$ 158	
Eligibility Expansion	Allow all eligible veterans to enroll	increase to 30% market share among priority 8	5%		\$ 72	\$ 140	
Initiatives	Nurse navigators for CDS care				\$ 71	\$ 138	
	Make veterans with Other than Honorable Discharges Temporarily Eligible for VA Health Care While Claims are Adjudicated				\$ 72	\$ 139	

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Additional Sample Cost Models

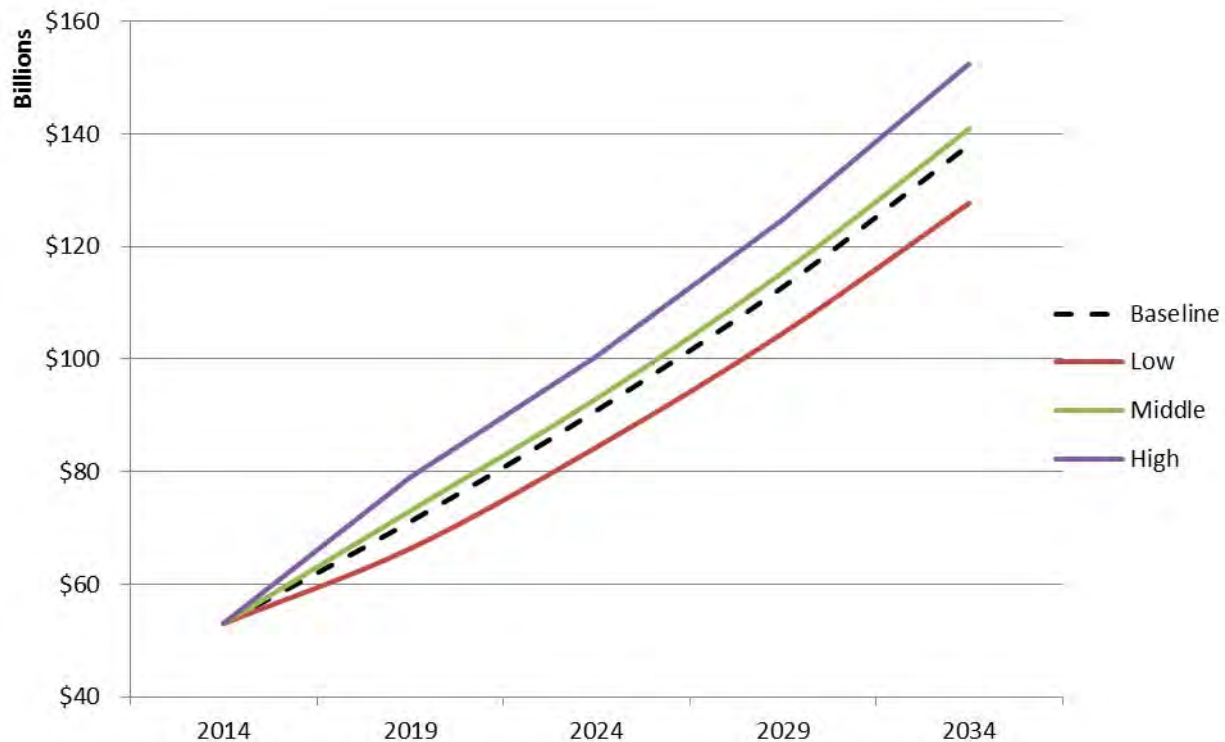
CDS Alternative 1

CDS Alternative 1 is similar to the Commission's *Recommended Option* above. The main difference is that a narrower subset of services is available in the CDS networks. Primary care, inpatient medical and surgical care, and some standard specialty care are not eligible for CDS networks and must be accessed within VA. The CDS network for *CDS Alternative 1* would focus on tertiary and quaternary care; it would not include primary care, some specialty care, inpatient medical and surgical care, and special-emphasis care (care that is provided in VA in a distinct fashion). In 2014, 47 percent of care would have been eligible for CDS networks.

Because less care is eligible for CDS networks than in the *Recommended Option*, less care will shift to CDS networks, reliance increases will be smaller, and enrollment increases will be smaller. We assumed that 50 percent of eligible care shifts from VA facilities to CDS networks. We modeled increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 46, and 51 percent. These reliance increases pertain only to CDS care, not CDS-eligible care provided in VA facilities. We modeled enrollment increases of 0, 5, and 10 percent. As in the *Recommended Option*, we assume newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks.

Figure A-3 displays estimates for CDS Alternative 1. Estimates range from \$66 billion to \$78 billion in 2019, with a middle estimate of \$73 billion. As in the *Recommended Option*, the middle estimate is close to the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to Medicare allowable rates for CDS networks and CITC offsets these effects.

Figure A-3. Projected Costs of CDS Alternative 1



CDS Alternative 2

Like *CDS Alternative 1*, CDS care in *Alternative 2* would focus on tertiary and quaternary care. CDS networks would not include primary care, special-emphasis care, inpatient medical and surgical care, and some types of specialty care.

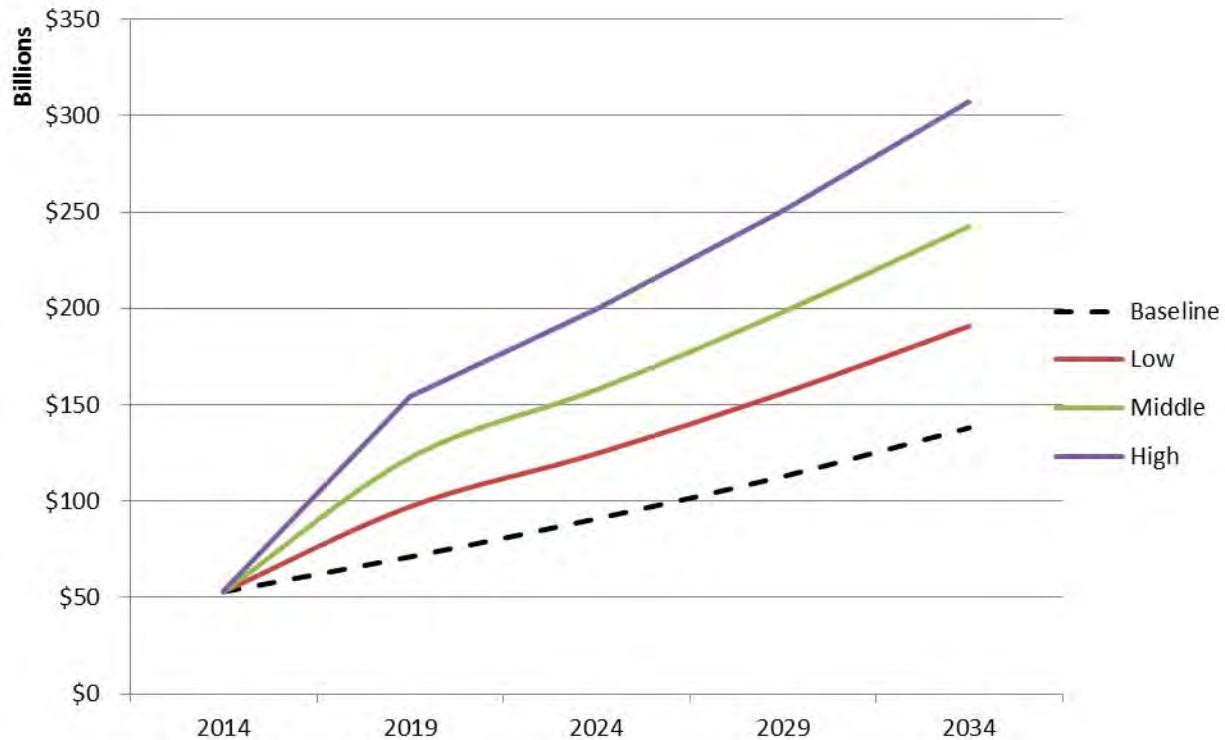
This option differs from the *Recommended Option* and *CDS Alternative 1* in that veterans must consult their VHA primary care provider in some way before seeking specialty care, but they *do not* need a referral to receive CDS eligible care whether they receive it in or out of VA. Some specialty care, all primary care, and all special-emphasis care are only provided in VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek eligible care in CDS networks is entirely up to the veteran. As in *CDS Alternative 2*, the care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

We expect reliance increases to be relatively high, and we apply these reliance increases to CDS eligible care regardless of where veterans receive it because referrals are not required for any CDS eligible care. Further, we expect enrollment increases to be higher than the *Recommended Option* and *CDS Alternative 1* because the absence of a referral requirement makes this a more attractive policy for potential enrollees. We model reliance rates of 60, 80, and 100 percent for care eligible for CDS networks; enrollment increases of 5, 10, and 20 percent; 70 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

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Estimates are displayed in Figure A-4. In 2019, the baseline projection is \$71 billion. *CDS Alternative 2* estimates range from \$97 billion to \$154 billion, with a middle estimate of \$123 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

Figure A-4. Projected Costs of CDS Alternative 2



CDS Alternative 3

CDS Alternative 3 differs from *Alternative 2* in two main ways. First, a broader array of care is eligible for CDS networks. CDS would include primary and standard specialty care, including inpatient medical and surgical care. It would not include special-emphasis care (care that is provided in VA in a distinct fashion). This array of eligible care is the same as that for the *Recommended Option*, and comprised 68 percent of total modeled expenditures in 2014. Second, enrollees do not need to consult with a primary care doctor in order to access CDS eligible care.

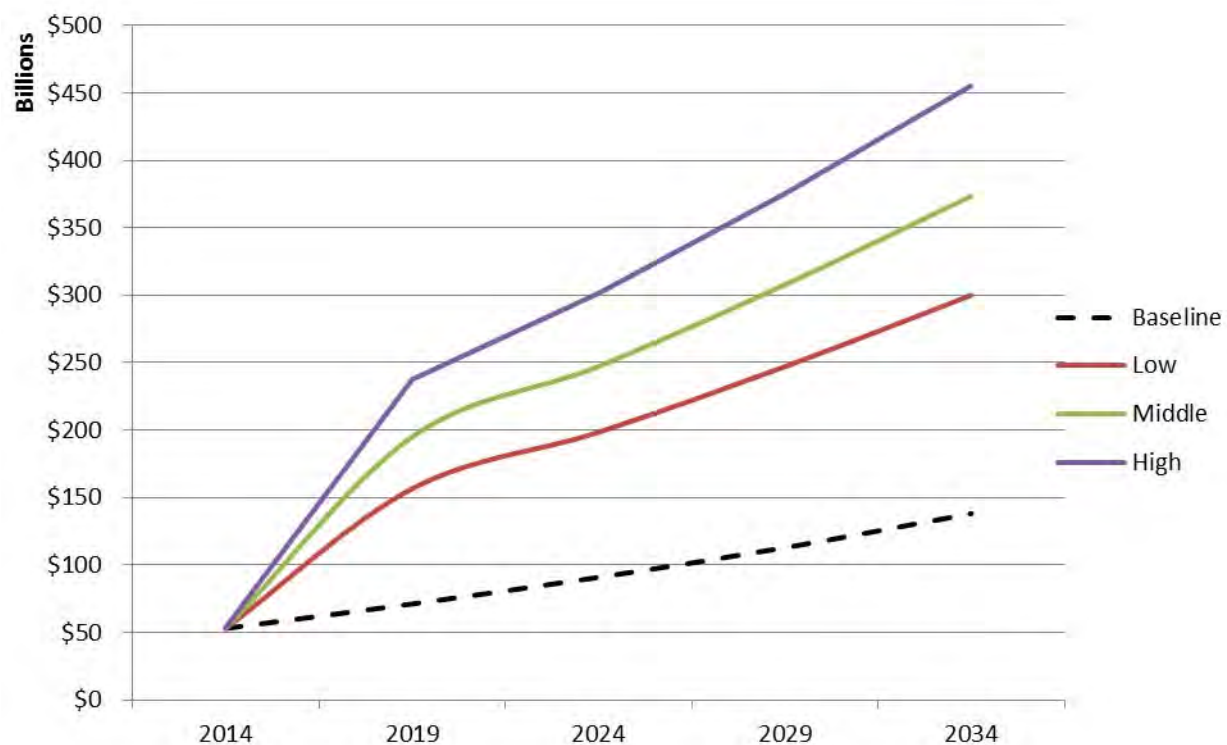
CDS Alternative 3 would offer an extremely generous benefits package for patients. With no referral or consultation, no premiums, and little if any copayments, patients would have access to a robust network of high-quality providers in their area. Although care within VA facilities would be available, no clinical contact would be necessary for those seeking care in CDS networks. Even within VA facilities, care is more attractive because patients would no longer need to consult their primary care doctors to receive specialty care. The benefits of this option contrast with the 10 to 30 percent cost sharing typical in Medicare and private coverage, the low

provider reimbursements, stigma and access barriers often associated with Medicaid,⁶⁷² and the requirements for referrals and/or prior authorizations that are widespread among health insurance plans. Few veterans would have reason to turn down such an attractive option.

Consequently, we model high ranges for reliance, enrollment, and care shifting into CDS networks. We model reliance rates of 80, 90, and 100 percent for all CDS eligible care; enrollment shares of 75, 85, and 95 percent; and a 70-percent rate of eligible care shifting from VA facilities to CDS networks. We apply the reliance increases to all care eligible for CDS networks, even if the care is provided in VA facilities or traditional CITC, because this option eliminates the need for consultations with primary care doctors for all CDS eligible care. Additionally, we assume that the total amount of CDS eligible care received by veterans from any provider and payer increases by 20 percent due to the lack of a referral requirement and/or reduced cost sharing.

Estimates are displayed in Figure A-5. In 2019, when effects are fully phased-in, estimated costs range from \$156 billion to \$237 billion, with a middle estimate of \$195 billion. This compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario, *Recommended Option*, and *CDS Alternatives 1 and 2*.

Figure A-5. Projected Costs of CDS Alternative 3



⁶⁷² Yu-Chu Shen and Stephen Zuckerman, “The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries,” *Health Services Research* 40, no. 3 (2005), 723-44. Jennifer Stuber and Karl Kronebusch, “Stigma and Other Determinants of Participation in TANF and Medicaid,” *Journal of Policy Analysis and Management* 23, no. 3 (2004), 509-530.

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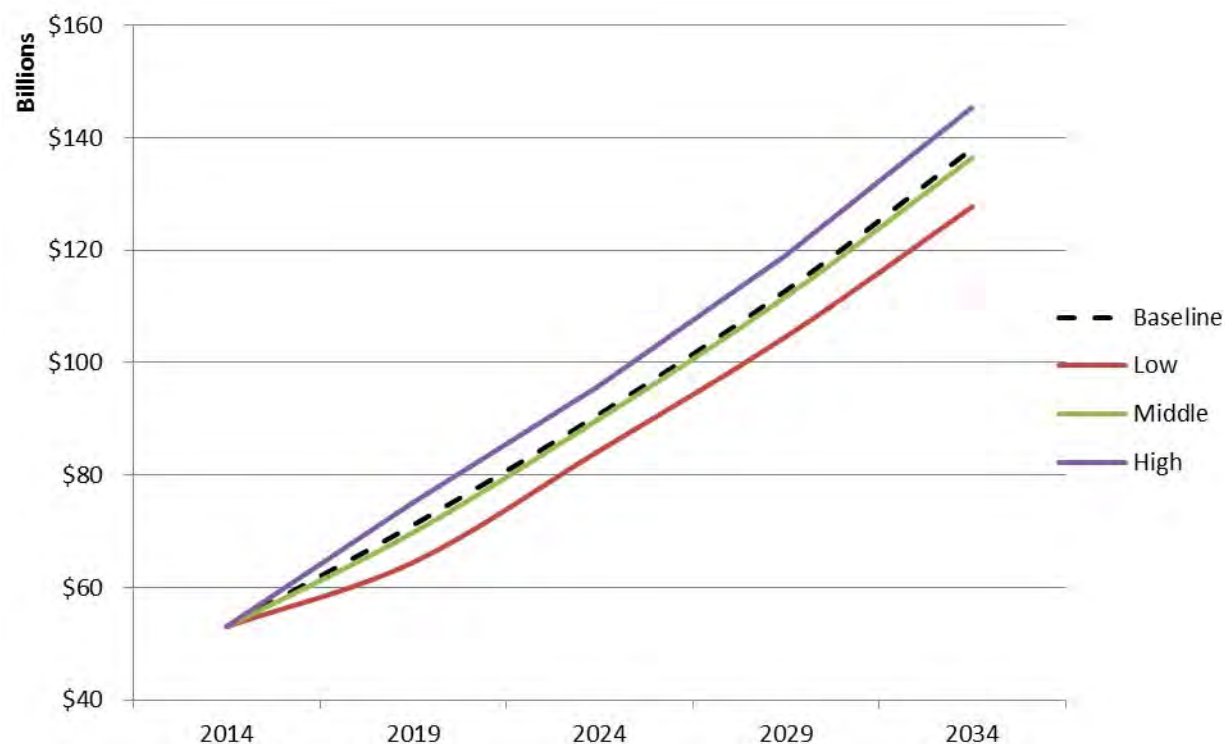
Keep Selected Services

The *Keep Selected Services (KSS)* scenario would move most standard ambulatory specialty care entirely into the community, yet keep the remainder of care entirely within VA facilities or traditional CITC. Although VA would no longer provide most standard ambulatory specialty care in VA facilities, it would continue to provide primary care, inpatient care, and special-emphasis care in VA facilities, including long term services and supports, prosthetics and orthotics services, inpatient and outpatient mental health and substance abuse, inpatient medical and surgical care, prescription drugs, medication management, recreational therapy, and immunizations. Under this scenario, approximately 35 percent of the cost of care currently provided in VA would be provided solely in the community. Providers in the community would receive Medicare rates.

We modeled increases in reliance of 10, 25, and 40 percent, which correspond to reliance rates of approximately 37, 43, and 48 percent. These reliance increases pertain only to care that moves into the community. We modeled enrollment increases of 0, 4, and 8 percent.

Estimates are displayed in Figure A-6. In 2019, when effects are fully phased-in, estimated costs range from \$64 billion to \$75 billion, with a middle estimate of \$70 billion. This estimate compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that even with expanded community care, cost increases are constrained when veterans cannot choose whether they receive care in VA facilities or in the community.

Figure A-6. Projected Costs of Keep Selected Services Scenario



Premium Support⁶⁷³

Under the *Premium Support* (PS) scenario, all current and future enrollees younger than age 65 can choose a subsidized insurance premium with cost sharing (for some priorities) in lieu of their current VHA benefit. Enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers. Under this scenario, there is an annual election period, and VA actively engages with enrollees to make a decision. Enrollees ages 65 and older receive no additional benefit options.

For those enrollees choosing the subsidized insurance program, the cost sharing varies by priority level: 10 percent for priorities 1 and 2; 20 percent for priorities 3 and 4; 30 percent for priorities 5 and 6; and 40 percent for priorities 7 and 8. Veterans would buy *Silver* policies on the state individual insurance exchanges, and VA would provide additional cost sharing assistance to meet the target subsidy. If enrollees purchased plans offered with lower cost sharing, such as *Gold* (20 percent cost sharing) or *Platinum* plans (10 percent cost sharing), the additional premium costs would likely exceed the cost of purchasing a Silver plan and subsidizing the cost sharing. The cost estimates did not consider the potential effect of adding a large number of veterans on exchange plans. Were VA to do this, considerations for veteran morbidity as well as the proposed cost sharing subsidies would need to be accounted for within the purchase of state exchange plans from commercial insurers.

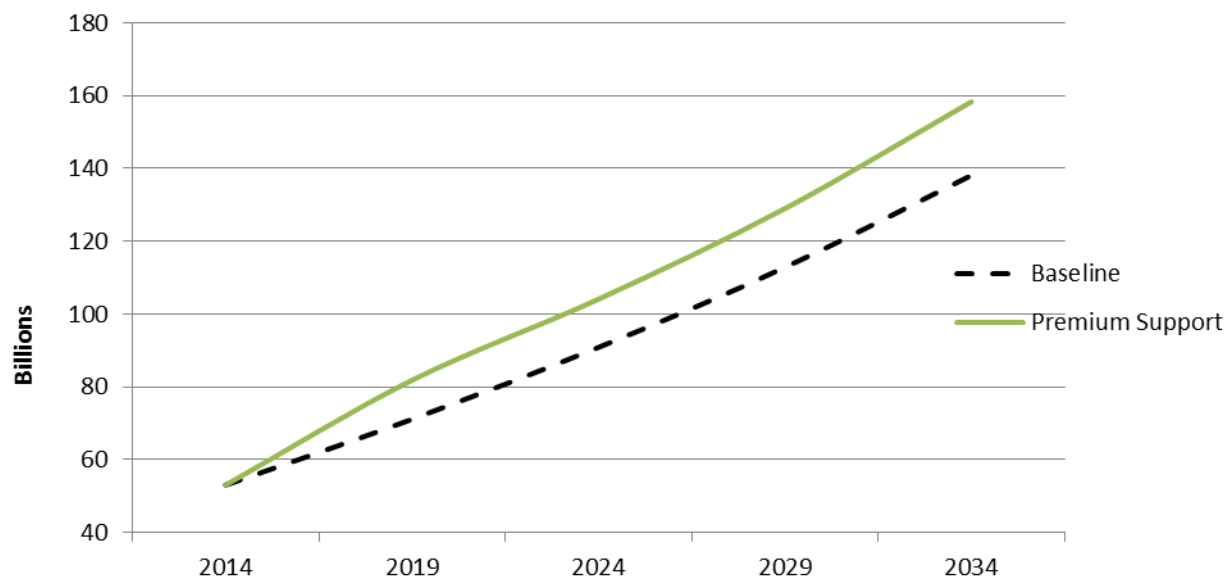
To determine participation rates in the subsidized premium program, we summarized enrollees' FY 2014 baseline data into cost brackets by attaching 2015 EHCPM unit costs to workload and then summarizing the total cost of workload provided to each enrollee. Overall, 42 percent of enrollees younger than age 65 were assumed to select the subsidized premium option, but the model assigned different rates of participation depending on enrollees' priority level and historical VA utilization. Enrollees with little to no costs were assumed to participate in the program at a higher rate as compared to those who had larger levels of VA costs. Participation rates for priority 5 veterans were assumed to be half the rates set for other priority levels. This assumption was made because many of these lower-income enrollees already have the option of participating in a highly subsidized state exchange plan with low cost sharing. It is also assumed that offering this option will motivate additional nonenrolled veterans to enroll to receive the subsidized premium plan. To estimate this effect, we analyzed the proportion of veterans by priority level with either no insurance or individual insurance plans, as reported in recent years of data captured by the American Community Survey (ACS). We estimated that this potential subsidy would lead to an additional 577,000 enrollees over the projection period.

Finally, it is assumed that the subsidized premium plan serves as a primary payer and does not supplement other coverage available to the enrollee, such as Medicare or employer sponsored insurance.

⁶⁷³ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

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Figure A-7. Projected Costs of Premium Support Scenario



Eligibility Expansion⁶⁷⁴

Under the *Eligibility Expansion* (EE) scenario, the VA health care system expands to allow all veterans to enroll in VA health care. In 2014, half of veterans eligible under priorities 1-7, 8b,⁶⁷⁵ and 8d were enrolled, representing a 50 percent *market share*,⁶⁷⁶ with the highest market share among those with service-connected priorities. The market share among Priorities 8a and 8c was an estimated 21 percent, reflecting enrollment from before suspension began in January 2003 and from enrollees who initially enrolled in another priority and later transitioned to Priorities 8a and 8c. If the suspension of new priority 8 enrollment had never occurred, we estimate that the market share would be 28 percent in 2014 and 30 percent in 2021 under natural growth and priority transition rates.

Under a scenario of lifting priority 8 enrollment suspension beginning in FY 2017, we estimate that the market share would climb steadily during a 5-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority 8 enrollees. The market share is not expected to reach the level observed among other priorities because Priority 8 veterans have higher incomes, are not service-connected disabled, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to other priorities. Further, regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans and veterans with employer-sponsored health insurance are all less likely to enroll. To develop the cost estimates, newly

⁶⁷⁴ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

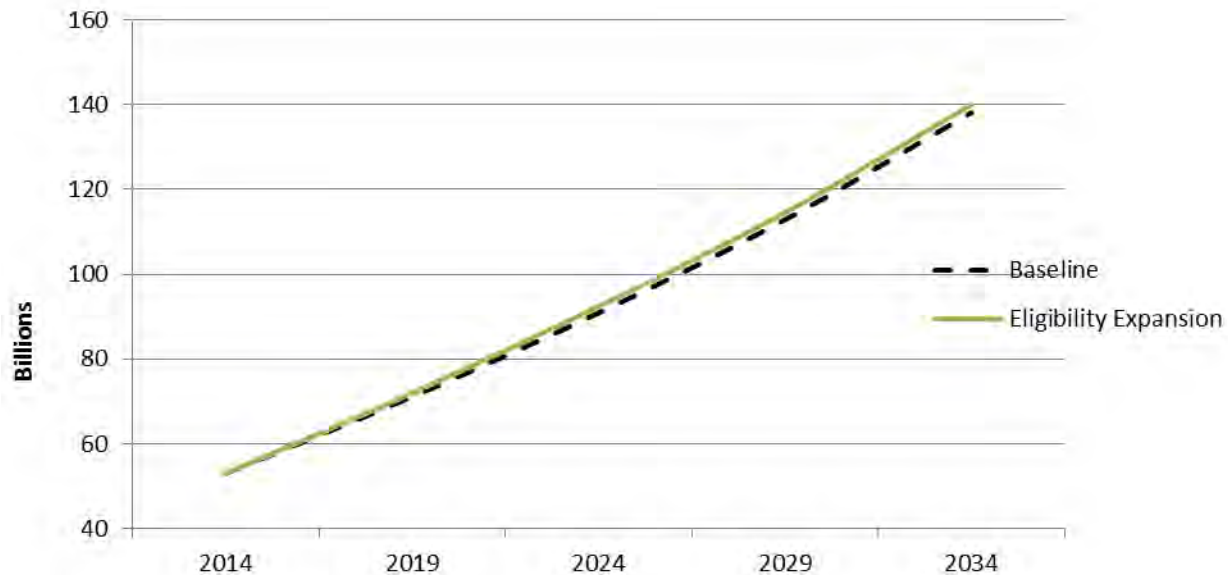
⁶⁷⁵ Priority 8b and 8d were enrolled on or after June 15, 2009 and have incomes that exceed the current VA or geographic income limits by 10 percent or less.

⁶⁷⁶ Market share is the percentage of veterans who are enrolled in VHA out of all veterans. This differs from the enrollment share, which is the percentage of eligible enrollees who are enrolled.

eligible priority 8 veterans are assumed to have the same morbidity and reliance as current priority 8 enrollees.

By 2032, based on the estimated market share, we project an additional 368,000 priority 8 enrollees with an additional \$1.8 billion in costs.

Figure A-8. Projected Costs of Eligibility Expansion Scenario



Additional Cost Factors

Nurse Navigators

VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special-emphasis PACTs, such as those for spinal cord injury and disorders, geriatrics, and HIV care. All patients may choose to be assigned to a primary care PACT, and the vast majority do so: There are approximately 5.3 million unique patients in primary care PACTs out of a total of 5.8 million.

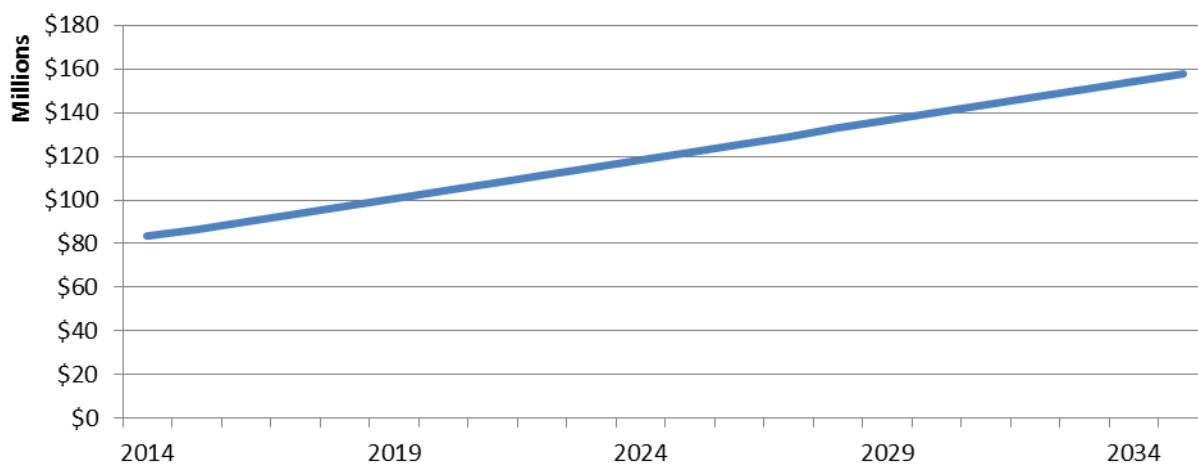
The primary care PACT typically consists of a provider, an RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1,200 patients. There are also expanded team members who are assigned to multiple panels, such as clinical pharmacy specialists, nutritionists, and behavioral health professionals. The RN care manager is the lynchpin of the primary care PACT.

One of the tasks of the care manager is to coordinate care received in VHA facilities with care received in the community. Because this coordination role would increase with the CDS scenarios, we provide a notional estimate for expanding the number of care managers to account for the additional administrative and clinical burden of an increase in community care.

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Based on discussions with VHA primary care operations and policy staff, we assume that one additional RN care manager per five panels would be necessary to handle a substantial increase in community care such as that associated with the CDS scenarios.⁶⁷⁷ Based on 2014 data on the number of patients in PACTs and the recommended panel size, we estimate that 882 RN care managers would need to be hired if the CDS scenarios were fully phased in. Incorporating the average total compensation of RN care managers (\$94.4 thousand in FY 2014) and inflating costs using the projected patient population and personnel inflation trend from the EHCPM, we generate the following cost estimates. These estimates are assumed to be fully phased in. The cost of this policy is \$100 million in 2019 and rises to \$158 million in 2034.

Figure A-9. Cost of Hiring Additional RN Care Managers



Other-than-Honorable Discharges

We also consider a policy for which those with an OTH discharge are made temporarily eligible for VA health care while their claims are adjudicated. The adjudication process would determine whether these individuals would remain eligible for care or would lose eligibility. Adjudication would be based on the reason for the discharge. For example, if the discharge were due to behavior associated with a mental health condition caused by serving in the military, that person would likely be positively adjudicated. However, the specific criteria for adjudicating cases still needs to be determined.

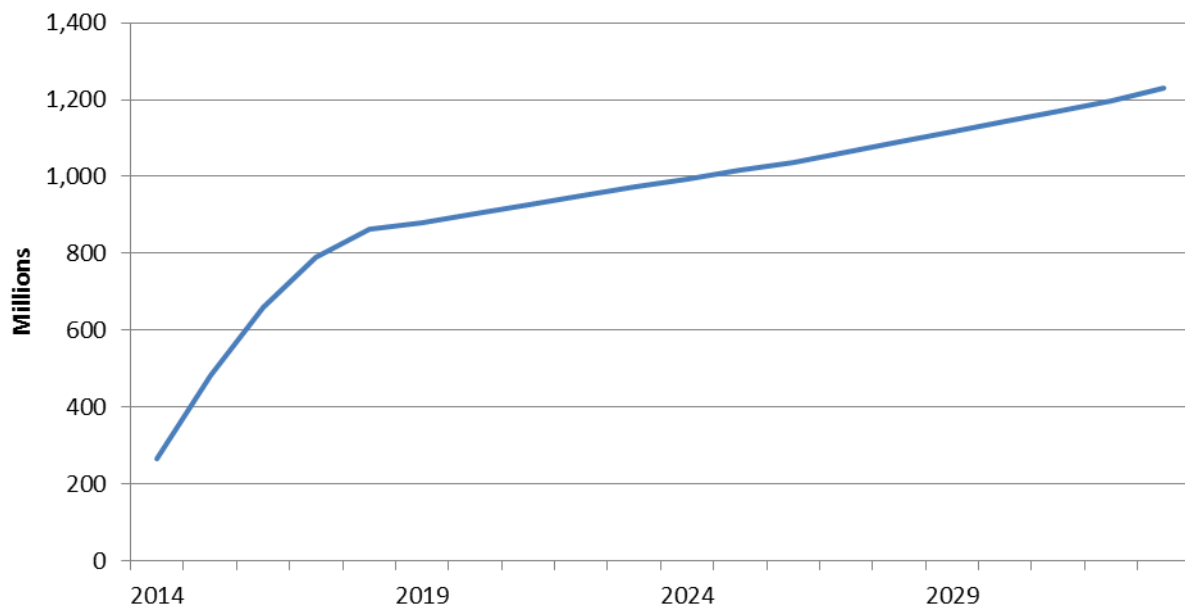
To model the cost of this proposal, we assume all people with an OTH discharge who would otherwise be eligible for VHA care are initially eligible. We assume that, consistent with the rest of the population, 73 percent of veterans with an OTH discharge are eligible for VA health care based on income and disability criteria. During a period of 5 years, their cases are examined, and 50 percent are positively adjudicated. Whether this number is actually higher or lower than 50 percent will depend on the exact details of the policy as well as the specific circumstances of veterans with an OTH discharge. In our model, the number of eligible veterans with an OTH discharge who enroll increases during the first 5 years as they become aware of the new rules. It

⁶⁷⁷ These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

increases to 52 percent, which is the enrollment share of veterans who are currently eligible. In reality, this rate could be higher or lower for those with an OTH discharge if they are different from those who are already eligible. We assume costs per patient are similar to other veterans of the same age.

The cost of this policy increases from \$264 million in 2014 to \$1.23 billion in 2033. Fully phased-in, the cost is \$864 million in 2019. The shape of the cost curve reflects increasing enrollment during the first 5 years as veterans learn about the new rule and sign up. It also reflects adjudications as all enrolled veterans are initially eligible and then their eligibility is adjudicated during the 5 years. These calculations reflect estimates that the number of veterans with an OTH discharge for active duty military has fallen from a high of 8.8 percent in 2002 to 2.1 percent in 2015. We assume that the rate continues at 2.1 percent of discharges throughout the projection window.

Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges



Conclusion

The estimated cost of allowing veterans to receive expanded community care through integrated networks varies dramatically depending on the specifics of the policy, including which categories of care are eligible for the community and whether referrals are required to access specialty care. We estimate that the *Recommended Option*, which provides increased community care that is reimbursed at Medicare allowable rates but maintains referrals for specialty care, increases costs modestly, assuming that networks are narrow and well-managed with cost as a major consideration. *CDS Alternative 1*, which offers a more restricted array of services eligible for CDS care, yet maintains a referral requirement, does not substantially increase costs. However, *CDS Alternative 3* and to a lesser degree *Alternative 2*, which eliminate the need for referrals for standard specialty care, potentially lead to very high costs. The estimated costs of the other scenarios range from small to substantial, though these costs would

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ultimately depend on the details of the proposals (e.g., the premium support schedule). Finally, we find that the costs of introducing expanded nurse navigators/care coordinators and making those with OTH discharge temporarily eligible are comparatively modest.

APPENDIX B: LEADERSHIP IMPLEMENTATION

Table B-1. Organizational Health and Cultural Transformation

Action	Responsible	Timeline
That VHA create a comprehensive, coordinated, sustainable cultural transformation effort by aligning programs and activities around a single, benchmarked concept.		
Establish the charter for the cross-functional SE team responsible for cultural transformation.	SECVA/DEPSECVA or CVCS depending on level	Now (0-6 mos)
Assess cultural transformation models and decide on a single model.	Chartered SE team	Now (0-6 mos)
Create an execution strategy for cultural transformation.	Chartered SE team	Now (0-6 mos)
Develop communication strategy and materials and release.	Chartered SE team	Near (18 mos)
That VHA aligns leaders at all levels in support of the cultural transformation strategy.		
Establish a subcommittee under the SE team to drive leadership transformation.	Chartered SE team	Near (6 mos)
Establish leadership standards for behaviors and actions.	Chartered SE team Subcommittee	Near (6-9 mos)
Publicize the standard.	Chartered SE team Subcommittee/CVCS/HTM	Near (12 mos)
Develop assessment tools.	SE Subcommittee/NCOD, NCEHC, HTM	Near (12-24 mos)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.	HTM/CVCS	Near (12-36 mos)
Provide coaching to the standard.	(Current HCM office responsible)	Near (24 mos)
Collect standards, training, support materials into a living curriculum for leaders.	EES/HTM	Near (24 mos)
Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and unacceptable performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.	HRA/HTM	Future (36 mos)
That VHA align frontline staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation.	Chartered SE team	Near (9 mos)
Establish behavioral expectations/requirements for staff.	Subcommittee	Near (9-18 mos)
Develop hiring tools against the staff standard.	Subcommittee	Near (18-36 mos)
Establish requirements (in policy) for use of the standard for IDP, performance reviews, advancement in grade/promotions.	HTM/HRA/nursing and similar/unions	Near (18-36 mos)

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Action	Responsible	Timeline
Support leaders and supervisors at all levels of the organization to communicate and reinforce these standards with staff (see align leaders, above).	(Policy owner)	Near (18 mos)
Establish program office and VAMC standards and strategy for execution.		
Establish subcommittee to develop VAMC and PO execution standards.	Chartered SE team	Near (18 mos)
Establish execution strategy and policy requirements.	Chartered SE team Subcommittee/NCEHC/ NCOD	Near (18-36 mos)
Develop consolidated, meaningful metrics with input from experts and field users.		
Assign responsibility for metric development.	Chartered SE team/CVCS	Near (6 mos)
Develop and test metrics.	Organizational Excellence	Near (6-18 mos)
Deploy metrics.	Chartered SE team/CVCS/ (policy owner)	Near (18 mos)
Identify outliers and intervene.	SE team/CVCS/(policy owner)	Near (24 mos)

Table B-2. Recruitment, Retention, Development, and Advancement

Action	Responsible	Timeline
VHA executives are required to make the leadership system a top priority for funding, strategic planning, and investment of their own time and attention.		
Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (3 mos)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018.	VHA OPP and CVCS	Now (3 mos)
Adopt VHA leadership management goal and submit to OMB/White House.	VA OPP and SECVA	Now (3 mos)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (4 mos)
Include yearly targets in the performance plan of the CVCS and SES members.	VHA NLC subcommittee on performance planning	Now (4 mos)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	CVCS	Now – ongoing
Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	CVCS	Now – ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.	CVCS /ask NLC executive committee to develop and implement a plan	Now (6 mos)
Adopt and implement a comprehensive system for leadership development and management.		
Convene a group to review ACHE and the National Center for Health Care Executives and devise a benchmarked model that meets the needs of health care executives in VHA as well as the private sector.	NCEHC with NCOD, & Human Capital Management; report to the NLC subcommittee for leadership development	Now (6 mos)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 mos)
Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.		
Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.	HTM with support as required from other offices, e.g., NCOD, EES	Near (within 18 mos)
Assess existing training against the model and identify gaps.	EES	Near (18 mos)
Develop and implement a plan to fill these gaps.	EES/reporting to NLC to ensure funding	Near (plan 20 mos – fill gaps 36 mos depending on \$)

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Action	Responsible	Timeline
Assess opportunities to share additional leadership training with DoD and create a plan to implement it.	HEC/JEC	Near (9 mos)
Develop and fund a face-to-face training to fulfill competencies for critical career positions.	EES	Near (24 mos)
Develop a masters level training program for clinical leaders in partnership with academic medicine.	EES/Academic Affiliations	Near (36 mos)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations.	EES/Academic Affiliations	Near (18 mos)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 mos)
Establish a coaching program.	HTM/EES	Near (18 mos)
Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).	HRA/EES/Workforce Management and Consulting	Near (18 mos)
VHA is required to aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: all hires and promotions are required to demonstrate these competencies.		
Create functional statements for all key positions based on the competency model.	HTM	Near (18 mos)
Create interview questions incorporating competencies for all key positions.	HTM	Near (12 mos)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 mos)
Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.	Human Capital Management	Near (18 mos)
Create regulatory requirements for the use of the competency model in hiring, promotion, development opportunities, and discipline; and incorporate procedures for veterans preferences.	Human Capital Management in VHA	Near (36 mos)
Establish an IDIQ, PBA or similar contract for executive recruitment.	Human Capital Management	Now (6 mos)
Establish requirement in policy for all ECF, SES / SES equivalent to complete IDP.	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF.	Human Capital Management / DoD Coordination	Now (6 mos)
Expand (GHATP) program.	EES	Now (6 mos)
Establish a plan for developing and managing the candidate pool.	NLC subcommittee for leadership	Now (6 mos)
Require a formal on boarding process for leaders at all levels that re-enforces the leadership competency model.		
Establish an onboarding curriculum and process.	Human Capital Management, EES, HTM	Now and Near (18 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
VHA is required to take immediate steps to stabilize the continuity of leadership.		
Extend authority for length of details and ability to compete for the detail position.	Human Capital Management	Now (6 mos)
Establish and fund assistant level positions in all key career development tracks.	CVCS	Now (18 mos)

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Table B-3. Organizational Structure and Function

Action	Responsible	Timeline
Eliminate duplication within VHA and consolidate program offices to create a flat structure.		
Eliminate the duplication of functions between VHA and VA by closing VHA offices.		
Create innovative organizational structures to support clinical delivery that are aligned to patient's needs rather than professional silos.		
Undertake a reduction-in-force (RIF) in VHACO that promotes delayering and efficiency in communication and decision making.		
Publish a new organizational chart consistent with Figure 9.	CVCS	Now (1 mos)
Prepare an initial RIF for offices eliminated.	VHA Human Capital Management	Now (3 mos)
Engage VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.	Transformation Office/ VERC	Near (3-12 mos)
Each program office in collaboration with VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings.	Transformation Office/ PO/ CVCS	Near (3-12 mos)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.	Transformation Office/ EES	Now (1 mos)
Develop training curriculum to support VHACO staff in developing the skills and competencies required.	Transformation Office/ EES	Near (18 mos)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.	Transformation Office/ CVCS	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VHACO employees.	Transformation Office/ EES	Now (6 mos)
Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.	Transformation Office/ EES	Near (12 mos)
Draft basic competencies for VHACO program staff (e.g., customer service, quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ Each PO	Near (18 mos)
Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.	Office of Organizational Excellence/OIT	Near (18 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
Clarify and specifically define the roles and responsibilities of the VISNs and facilities, pushing decision making down to the lowest level.		
Publish clear roles, responsibilities and expectations that apply to the VISNs.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN.	Transformation Office/ EES	Now (1 mos)
Develop an engagement strategy to inspire VISN staff to embrace their new role and tie to in-service training roll out.	VISN directors	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VISN employees.	Transformation Office/ EES	Now (6 mos)
Draft basic competencies for VISN staff (e.g., quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ each PO	Near (18 mos)
Gain agreement from Congress to institute three appropriation lines only: medical, major construction, research.	CVCS/SECVA/OMB	Near (12 mos)
Eliminate segregation of specific-purpose funds to the VISNs and facilities.	CVCS/Office of Finance	Now (6 mos)
Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending.	OIT/Office of Finance	Future (36 mos)
Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out.	Finance/EES	TBD post procurement
Establish quarterly spend reports covering all priority areas (e.g., NRM, IT, facility minor, purchased care, mental health, women's health, administration) by facility and release to Congress and the public.	Finance Office	TBD post procurement
Delegate decisions in recruitment, retention and advancement (e.g., hiring bonus, retention bonus, market pay) for staffing to the facility.	CVCS/HCM	Now (1 mos)
Delegate training and travel decisions.	CVCS/EES/OAA	Now (1 mos)
The USH establishes leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.		
Improve communication with field leadership and frontline employees through the liberal use of social media, town halls and other direct engagement channels with a dedicated champion to help the USH and senior staff in this endeavor.	CVCS	Now (3 mos)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	CVCS/EES/NLC	Now (6 mos)
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	CVCS	Near (12 mos)

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Action	Responsible	Timeline
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	CVCS	Now (3 mos)
Establish a transformation office with broad authority and a supporting budget to accomplish the change.		
Establish the new transformation office in the organizational chart, populate with expertise in business process re-engineering, and fund initially using savings from closure and consolidation of offices in VHACO and a budget reduction to all other VHACO offices.	CVCS	Now (6 mos)
Create a Transformation Office strategic plan to educate and provide guidance to the new initiatives and support the goals of VA and VHA.	Transformation Office	Near (3-6 mos)
Create a new initiative implementation plan to include follow-on priorities, tasks and milestones. The Transformation Office will support the operation and the plan moving forward.	Transformation Office	Near (3-6mos)
The Transformation Office will be responsible for evaluating all new initiatives and programs using the President's Management Agenda Scorecard or a model that emulates its rating standards of Green represents success; yellow for mixed results; and red for unsatisfactory. These ratings are indicative of standards of success or failure.	Transformation Office	Near (3-6mos)

Table B-4. Performance Metrics and Management

Action	Responsible	Timeline
Create a new performance management system for VHA leaders appropriate for health care executives.		
Establish a workgroup and engage outside experts to create the new performance management system that is benchmarked to private-sector models, is consistent with the new leadership competency model, and recognizes both leadership competencies and success in delivering strategic priorities. The model should include a new rating scale.	Transformation Office/Human Capital Management	Now (6 mos)
Develop and conduct training on the new performance management system for all participants to describe the system, rating process, and expectations.	Human Capital Management	Near (6-12 mos)
Establish a mechanism to capture performance assessment outcomes and track and manage high-potential staff.	Human Capital Management/HRA	Now (3 mos)
Establish a project plan to deliver annual guidance on performance plans at least a month in advance of the new fiscal year (i.e., at the start of the new rating period).	Human Capital Management/CVCS/Sec/OMB	Now (3 mos)
Hold raters accountable for creating meaningful distinctions between leaders.		
Provide training to raters on the application of the new performance management system and expectations for ratings.	Human Capital Management	Future (12 mos)
Require raters to establish plans for subordinates that are timely and meaningful; track and provide feedback on meeting this goal.	Human Capital Management/HRA	Now (3 mos)
By modeling the behavior and communicating the requirement, establish expectations that raters, and secondary-level raters, engage in continuous dialogue and coaching with subordinates about performance throughout the year, not just at mid-year and at the end of the rating period.	CVCS	Now (3 mos)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation.	Human Capital Management/CVCS	Now (12 mos)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance.	Supervisors	Near (12 mos)

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Table B-5. Leadership Implementation: Human Capital Management

Action	Responsible	Timeline
VA re-align HR functions and processes to be consistent with best practice standards of high-performing health care systems.		
Charge HRA to undertake an HR transformation study and ensure budget and solicitation of customer requirements.	SECVA/DEPSECVA	Now (0-6 mos)
Engage HR and change management experts to develop a benchmark human capital management plan for VA.	HRA	Now (0-6 mos)
Circulate new human capital plan for feedback and finalize.	HRA with input from VHA, Congress, OPM, OMB, SECVA/DEPSECVA, CVCS	Now (6 mos)
That VA and VHA leaders make transformation of Human Capital management a priority, with adequate attention, funding and continuity of vision.		
Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.	SECVA/DEPSECVA and CVCS, as applicable	Near (9 mos)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12-30 mos)
Create an HR IT technology plan.	HRA & OIT	Near (9 mos)
Establish meaningful measures and risk indicators for VA human capital management.	HRA	Future (24 mos)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders.	HRA, DEPSECVA, CVCS as appropriate	Near (18 mos)
VA develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES).		
Develop clear standards, guidelines, and training on progressive discipline.	HRA (with support from OPM)	Now (6 mos)
Managers, supervisors and HR professionals complete training.	SECVA/ DEPSECVA and CVCS (HTM office)	Near (12 mos)
Train HR staff to be coaches in progressive discipline.	HRA	Now (6-12 mos)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process.	HRA	Near (12 mos)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process.	SECVA/ DEPSECVA, CVCS	Near (12 mos)

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE

As discussed in Recommendation #18, some Commissioners support the idea of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.

Problem

In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. This trend is driven by four main factors: (a) the overall decline in the size of veterans population, (b) the migration of veterans away from some parts of the country, such as New England and the Upper-Midwest, (c) the general trend in health care toward less intensive use of acute-care hospital beds, and (d) increased use of purchased care, which now accounts for 27 percent of all appointments.

A related challenge is maintaining safe volume of care when patient loads decline. As extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁷⁸

Simply closing a low-volume hospital is sometimes the answer. But closing a local VA hospital may mean that area veterans will have reduced access not only to routine, but also to specialty care related to their military service, such as for spinal cord or traumatic brain injuries. In many areas, such care is not available or is in short supply outside VHA.

At the same time, it may not be clinically feasible for VHA to engage in highly specialized care if it lacks the ability to offer other forms of care in the same setting. Patients in a polytrauma unit for example, require a full-spectrum of routine and nonroutine health care.

Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. Toward that end, VHA could develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans in these areas to purchase VHA care through their health plans. These pilots could be tested in conjunction with the growth of the high-performance, integrated VHA networks recommended elsewhere in this report. These networks will allow VHA far more flexibility than in the past to expand or contract its local capacity in different markets as appropriate.

⁶⁷⁸ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

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Background***Current Nonveteran Access to VHA Care***

VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of \$1.9 billion in 2015,⁶⁷⁹ or 3.6 percent of total VHA obligations.⁶⁸⁰

By far the largest subgroup within the nonveteran patient population are participants in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or spouses of veterans who at the time of death were rated permanently and totally disabled from a service-connected condition.

Congress authorized CHAMPVA in 1973. The authorization specifies that VHA is the secondary payer for those with Medicare Part A and B coverage. In cases for which VA medical facilities are equipped to provide the care, VA may use facilities not being used for the care of veterans to provide services to the dependent or survivor.

Congress has also directed VHA to offer specific health care services to many other classes of nonveterans. These include mental health and counseling services for family caregivers of seriously injured veterans of post-9/11 service. Several provisions of law also authorize VA care for certain family members of veterans who were exposed to toxic substances. In the case of veterans with 50 percent or more service-connected disability, VHA must provide by law “consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with” the veteran’s treatment.⁶⁸¹

Analysis

Others who have developed strategic plans for the long-term future of VA health care have recommended expanding upon these precedents, specifically by allowing currently ineligible veterans and the spouses of veterans to purchase VHA care.⁶⁸² In effect, providing such care would allow VHA to operate as an accountable care organization, capable of receiving reimbursement from patients covered by Medicare, Medicaid, as well as by private insurance plans. Among the potential benefits envisioned are the following:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities
- preserving mission critical veterans’ programs that would otherwise need to be terminated in many parts of the country
- optimizing the integration of VHA and non-VHA care within communities

⁶⁷⁹ Allocation Resource Center, information provided to Commission on Care, December 8, 2015.

⁶⁸⁰ Department of Veterans Affairs, “Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2016 Funding and FY 2017 Advance Appropriations,” accessed May 27, 2016, <http://www.va.gov/budget/products.asp>.

⁶⁸¹ Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S.C. § 1782.

⁶⁸² Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed May 27, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

- providing a *public option* for health care to a wider range of veterans as well as nonveterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans' healthcare

The pilot projects described below would specifically evaluate whether such a strategy will allow VHA to optimize the quality and cost-effectiveness of its health care system by avoiding low volumes of routine and specialty care in certain sections of the country. These pilot projects would also allow VHA to evaluate whether such a strategy could provide new revenues for sustaining the VA health system while providing other benefits to veterans and the public at large.

The chart below sketches six possible pilot projects designed to test different specific policy configurations. The configurations include projects in which VA care is marketed to health care plans on fee-for-service (FFS) basis, and plans in which VA facilities are markets to health care plans as Accountable Care Organizations that provide integrated health services to a fixed population of insured patients for a fixed cost.

*Demonstration Projects to Assess VHA's Capability to Treat
Nonveteran Spouses and Ineligible Priority 8 Veterans*

	Eligibility	Capitation/Fee For Service	Timing
Demonstration 1: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: FFS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) with private insurance	FFS	Years 3-8
Demonstration 4: FSS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance and/or Medicare	FFS	Years 3-8
Demonstrations 5 and 6: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses	Enrollment: May choose higher cost plan with more coverage and less copayment; lower cost option with less coverage and higher copayments.	Years 4-9

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	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 7 and 8: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses with private insurance and/or Medicare	Enrollment: May choose higher cost plan with more coverage and less copayment; or lower cost option with less coverage and higher copayments. Pilot sites would be deemed Accountable Health Care Organizations for Medicare Advantage plans.	Years 5-10

Certification of Access: Any participating VHA facility must certify that its waiting times for primary care, specialty care and behavioral health are less than 30 days.

Site selection: Sites should include facilities in different regions with various population densities (urban, suburban, rural) and levels of service complexity. VHA may also consider such factors as stability of medical center leadership, and whether local markets are underserved or subject to high degrees of market concentration among either providers or payers.

Assumptions

- Many provisions are subject to Congressional authorization.
- Participating VHA facilities will be able to retain any “profit” associated with treatment of new users without offset;
- Congress will (preferably) waive the current prohibition on Medicare funding federal health care programs,
- VHA will not be subject to proving “level of effort” in order to receive Medicare funds

Assessment

After the first year of operations, VHA will assess these projects according the following criteria:

- Was access to care or patient satisfaction among veterans already enrolled in the system affected by the demonstration?
- What was the level of patient satisfaction among new users purchasing VA care?
- Did VHA cover the costs of delivering care to its patients purchasing care? If so, what were its net revenues and how were they used?
- If VHA collected Medicare funds, did funding cover costs of delivering care?

APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- Were there administrative challenges in opening the VHA to new users? If so, what lessons were learned?
- How did VHA promote the demonstration project to those eligible?
- What are the recommended strategies for further implementation?
- Were there non-financial benefits to treatment of new users, such as diversifying case mix, providing sufficient volume to allow certain VHA services to remain available, or keeping scarce health professionals employed in an area that is medically underserved?
- How did the demonstrations affect the overall quality of care, market structure, pricing, and range of health care options available to both veterans and nonveterans in the surrounding community?

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APPENDIX D:

HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION

History provides opportunities to see the problems and challenges facing VHA today through the lens of recurring themes from the past. Veterans' health care has, over the course of its history, been marked by periods of both progress and problems. Understanding the challenges of the past and the solutions used to address them provides context for building a plan for reforming veterans' health care in a manner that is flexible and sustainable.

Challenges and Growth

The federal government's role as a care provider for veterans has evolved, paralleling, to some extent, medicine's evolution. Prior to World War I, the only benefits afforded then-eligible veterans were pensions and domiciliary care (which involved only incidental medical treatment), provided under the National Home for Disabled Volunteer Soldiers and Sailors established after the Civil War.⁶⁸³

World War I brought real change. At the time, no single agency was responsible for the anticipated deluge of sick and wounded soldiers. The more than 200,000 wounded who returned home from battle quickly exceeded capacity of the U.S. Public Health Service (PHS), the National Home, and other agencies. According to one account of the period, "[c]haos and confusion reigned for more than two years . . . [n]ew hospital construction languished," and "[b]y 1921, veterans' care had become a national embarrassment."⁶⁸⁴ At the recommendation of a presidential committee, Congress passed legislation in 1921 to consolidate the several veterans-related bureaucracies into a single Veterans Bureau, to which the President Warren Harding transferred 57 PHS hospitals. A new administrator, Frank T. Hines, proposed care and treatment of veterans' non-service-connected ailments when facilities and bed space were available. Congress adopted the proposal in the World War Veterans Act of 1924.⁶⁸⁵

Under Hines' tenure, VA grew from 64 to 91 hospitals, nearly doubling bed capacity. Civil Service Commission personnel rules and low pay led to generally poor quality VA physicians, yet Congress rebuffed VA proposals to set up a VA Medical Corps.⁶⁸⁶ With many physicians having left VA to serve in World War II or for more lucrative practice, the VA health care system was left critically understaffed.⁶⁸⁷

⁶⁸³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 4.

⁶⁸⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 13-14.

⁶⁸⁵ *Ibid.*, 19.

⁶⁸⁶ *Ibid.*, 21.

⁶⁸⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 149.

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World War II and the need to care for millions of service members, including 671,000 wounded, highlighted the problems facing VA. Scathing reports of shoddy veterans' care, including an exposé characterizing veterans' hospitals as backwaters of medicine, magnified the problems.⁶⁸⁸

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed to head the agency, with its network of 97 hospitals, and a need for more.⁶⁸⁹ Dr. Paul Magnuson, who served as VA's chief medical director (CMD) from 1948 to 1951, later described the conditions at the time:

The majority of Veterans Administration hospitals were stuck in far off places, some of them on Indian reservations, others as much as fifty miles from the nearest through-line railway stop. The doctors were all full-time Civil Service employees, hemmed in by regulations and practically forbidden to do any research, attend any medical meetings or otherwise keep in touch with scientific progress. Operating rooms closed at noon so everybody could spend the afternoon happily doing required paperwork, while patients waited days and weeks for surgery.⁶⁹⁰

With President Harry Truman's statement that "the Veterans Administration will be modernized," new VA leadership worked with Congress to pass far-reaching legislation, Public Law 293, which created a VA Department of Medicine and Surgery (DM&S), and freed VA physicians, dentists, and nurses from the Civil Service Commission and its rules.⁶⁹¹ Within weeks, the chief medical director of the new DM&S issued a policy memorandum that outlined a cooperative affiliation agreement between VA and medical schools under which deans' committees would recommend consultants and attending physicians for appointment to VA, and residency-training programs would be established at VA hospitals. The law, and Policy Memorandum #2, broke a recruitment logjam and enabled the short-staffed department to hire medical professionals needed for the dozens of new VA hospitals being built. Soon after, medical students and residents began working in 32 VA hospitals. The reforms instituted under Bradley and his team were palpable,⁶⁹² with the physician staff at VA hospitals increasing from 2,300 (1,700 of whom were detailed by the military) in June 1945 to 4,000 full-time staff a year later.⁶⁹³ By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.⁶⁹⁴

After this turn-around, Bradley left to become Army Chief of Staff, and under his successor, "who did not enjoy the same level of prestige and support that Bradley did . . . VA quickly

⁶⁸⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 22.

⁶⁸⁹ Ibid., 23-25.

⁶⁹⁰ Ibid., 22.

⁶⁹¹ "31: The President's News Conference," Harry S. Truman Library & Museum, accessed June 3, 2016, <http://trumanlibrary.org/publicpapers/viewpapers.php?pid=38>.

⁶⁹² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 27.

⁶⁹³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 214.

⁶⁹⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 28.

reverted to its pre-Bradley ways and remained that way for the next forty years,”⁶⁹⁵ according to one account.

By the early 1950s, the veteran population had grown to more than 20 million.⁶⁹⁶ VA was operating 162 hospitals, with an average census of more than 104,000 patients.⁶⁹⁷ A VA historian observed that “waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals.”⁶⁹⁸ At the time, non-service-connected veterans seeking care had to state under oath that they could not afford to pay for hospitalization, and admission was granted only when beds were available in VA or other federal hospitals.⁶⁹⁹ Critics called for reducing free medical care of non-service-connected veterans, and questioned whether some were getting care that they could afford. This issue led VA to institute a policy of formal counseling under which hospitals would supply the veterans with an estimated cost of care to assist them in determining their ability to pay.⁷⁰⁰

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.⁷⁰¹ During this period, annual debates over the DM&S budget centered on the number of beds VA should operate. VA leaders contended that the number should be 125,000, yet the director of the Bureau of the Budget (the predecessor to the Office of Management and Budget [OMB]) asserted 87,000 was sufficient.⁷⁰²

The expiration of the incumbent CMD’s term led to the appointment in 1955 of medical educator Dr. William Middleton, dean of the Wisconsin Medical School, and a long-time member of a VA special medical advisory group. One of his first acts as CMD was to champion medical research in VA and broaden its scope to include geriatric research. Soon after, Congress began earmarking funds for VA research, and expanded DM&S’ statutory role to include medical research.⁷⁰³ During Middleton’s tenure, from 1955 to 1963, VA research funding grew from some \$6 million to more than \$30 million.⁷⁰⁴ Middleton’s work laid the foundation for a research program long recognized for pioneering important medical technologies, including medical use of radioisotopes, dialysis, cardiac pacemakers, liver transplantation, as well as seminal studies that documented the benefits of coronary artery bypass surgery and drug treatment of hypertension.⁷⁰⁵ The program also stood out for its capacity to design and rapidly implement large-scale cooperative trials, first mounted in the 1950s with successful evaluation

⁶⁹⁵ Ibid., 29.

⁶⁹⁶ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 254.

⁶⁹⁷ Ibid.

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid., 253.

⁷⁰⁰ Ibid., 253-254.

⁷⁰¹ Ibid., 256.

⁷⁰² Ibid., 258.

⁷⁰³ Ibid., 262-263.

⁷⁰⁴ Ibid., 263-264.

⁷⁰⁵ Stanley Zucker et al., “Veterans Administration Support for Medical Research: Opinions of the Endangered Species of Physician-Scientists,” *The FASEB Journal*, 18, no. 13, (2004): 1481-1486, <http://doi.org/10.1096/fj.04-1573lfe>.

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of chemotherapy for tuberculosis.⁷⁰⁶ Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat posttraumatic stress disorder.⁷⁰⁷

Middleton expanded the VA educational program. In addition to growing the number of medical residents it helped train, VA provided training to a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, social work students, and dietetic interns. Middleton instituted numerous advances in VA care such as introducing outpatient care for preadmission workups and post-hospital treatment that allowed earlier release from inpatient stays. He moved VA away from operating hospitals for specific diseases (as had been done for tuberculosis and mental illness).⁷⁰⁸

The enactment of Medicare in 1965 raised questions about the effect that program would have on the VA health care system. The House Veterans Affairs Committee sent a questionnaire to a group of 10,000 veterans explaining the new program and asking the veteran to if they preferred VA care or treatment in a community hospital under Medicare.⁷⁰⁹ Some 59 percent responded, and nearly two-thirds of respondents preferred VA.⁷¹⁰ At the time, the policy governing those eligible for VA care based on financial need was that Medicare benefits were to be considered in determining an individual's ability to pay for needed care.⁷¹¹

The enactment of Medicare and other changes in health care in 1977, led to a commission being established by the National Academy of Sciences (NAS) which issued a report pursuant to a congressional directive to evaluate the VA health care system. Among its findings, the commission reported that VA had a surplus of acute beds and recommended that new facilities be constructed only after examining bed availability in the community. It also recommended that underutilized VA hospitals be closed or converted to long-term care facilities, and resources redistributed to permit a shift from inpatient to outpatient care. The NAS commission also recommended that VA experiment with models for community-based integrated care.⁷¹² The commission's recommendation for integrating the VA system into the nation's civilian health care program⁷¹³ provoked objection, particularly in Congress.⁷¹⁴ Hearings produced sharp rejections of the NAS commission findings and its call to end VA's role in providing health care to veterans.

⁷⁰⁶ Ibid.

⁷⁰⁷ Veterans Health Administration, *History of VA Research Accomplishments*, accessed June 3, 2016, http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.

⁷⁰⁸ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 265-267.

⁷⁰⁹ Ibid., 390.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

⁷¹³ J. William Hollingsworth and Philip K. Bondy, "The Role of Veterans Affairs Hospitals in the Health Care System," *New England Journal of Medicine*, 322, no. 10, (1990): 1851-1857, <http://doi.org/10.1056/NEJM199006283222605>.

⁷¹⁴ *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

The VA of the 1970s and 1980s is remembered as bureaucratic, reliant on paper health care records, and driven by patient admissions (on which budgets were based).⁷¹⁵ The quality of VA care was also an issue. Complaints from Vietnam veterans and critical media accounts fueled outrage, and led to the view that the system was broken. The question, how to fix it, reopened an earlier dialogue around making VA a cabinet-level department, a view strongly supported by veterans service organizations (VSOs) and veterans' leaders in the House of Representatives. In 1988, after years of debate, and opposition from administration offices and advisors, President Reagan signed legislation creating a Department of Veterans Affairs.⁷¹⁶ The new department, with DM&S now renamed the Veterans Health Services and Research Administration (to emphasize its research legacy in such fields as infectious disease, pacemaker technology, and prosthetics), employed some 194,000 people with a \$12 billion budget.⁷¹⁷

Facing an aging veteran population⁷¹⁸ expected to overwhelm the system by 2010, the new secretary, Edward Derwinski, in 1989 requested Congress establish an independent commission to review the alignment and mission structure of VA's hospitals. Congress rebuffed the request after VSOs, suspecting a plan to close hospitals, lobbied against it.⁷¹⁹ Derwinski created his own "Commission on the Future Structure of Veterans Health Care" that was to review all VA hospitals and recommend needed mission changes. Instead, the so-called Mission Commission called for expanding eligibility law to enable veterans to obtain the full continuum of VA health care services. Although the commission identified the need for fundamental restructuring of the VA health care system, the subject was soon overtaken by national health reform proposals, and what role VA might have under a universal coverage system.⁷²⁰

Dr. James Holsinger, a new under secretary for health (USH), made care quality a top goal and issued a Blueprint for Quality tool in 1992, setting the stage for more far-reaching changes instituted by his successor, Dr. Kenneth Kizer. Care quality, a perennial topic, had led to the previous under secretary's resignation following reports of multiple veterans' deaths under questionable circumstances at VA's North Chicago medical center.⁷²¹ Two years later, Derwinski lost his job after creating ire among veterans' organizations in response to his proposed pilot program to open two VA hospitals to poor, rural nonveterans.⁷²²

⁷¹⁵ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 30-31.

⁷¹⁶ Ibid., 33-40.

⁷¹⁷ Ibid., 50.

⁷¹⁸ As the General Accounting Office reported in 1990, "The Department of Veterans Affairs (VA) faces a major challenge: planning how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years old and over is projected to grow to 9 million by 2000—a 50percent increase over the 1988 level.

U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷¹⁹ U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), 51, accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷²⁰ U.S. Government Accountability Office, *Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform*, GAO/HEHS-95-14 (Washington, DC, 1994), accessed June 20, 2016, <http://archive.gao.gov/f0902a/153054.pdf>.

⁷²¹ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 53.

⁷²² "Angry Veterans Groups Say They Made Bush Oust Agency's Head," Eric Schmitt, accessed June 3, 2016, <http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html>.

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Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.⁷²³ Among Brown's most important early acts was selecting Dr. Kenneth Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the USH post.⁷²⁴ With experience heading the California department of public health, Kizer saw health care as a system, and data as a tool to improve it.⁷²⁵

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, integration of services, and realigned payment policies.⁷²⁶ His vision was large and bold, underscored by his belief that "we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly we should not exist."⁷²⁷ At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.⁷²⁸ He set the tone for what was to come at a meeting with senior managers at which he stated,

*The old culture must give way to a new culture . . . that is based on innovation and creativity; a culture based on personal initiative and individual and collective accountability; a culture that is based on outcomes and heightened productivity; and a culture that is committed to change.*⁷²⁹

Among his first steps was the development of what was to become a Vision for Change, a new organizational model to restructure both field operations and central office management. At its core was the creation of 22 veterans integrated service networks, or VISNs, (replacing four regions which had been responsible for overseeing 40 to 45 hospitals each), with decision making shifted away from VA Central Office (VACO) to the new VISN directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.⁷³⁰ Each VISN was in charge of all the care provided to veterans in that network, and each was funded on a capitated basis rather than based on historical costs.⁷³¹ The VACO structure would be marked by its *flatness*, foregoing a tiered hierarchy.⁷³²

⁷²³ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 89.

⁷²⁴ *Ibid.*, 92.

⁷²⁵ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 50-51.

⁷²⁶ Ashish K. Jha et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, 348, no. 22, (2003): 2218-2227, accessed June 20, 2016, <http://doi.org/10.1056/NEJMsa021899>.

⁷²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 51.

⁷²⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 97-8.

⁷²⁹ *Ibid.*, 105.

⁷³⁰ *Ibid.*, 110.

⁷³¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation," Ashish K. Jha, accessed June 3, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31>.

⁷³² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 111.

The system Kizer and his team inherited was characterized by a multitude of problems.⁷³³ Kizer and his team literally reengineered the veterans' health care system based on a set of transformation strategies: to create management accountability, integrate and coordinate services, improve the quality of care, align system finances with desired outcomes, and modernize information management.⁷³⁴

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,⁷³⁵ and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.⁷³⁶

Some of Kizer's successes involved winning support within the administration and from Congress for bold initiatives. He won a critical concession from OMB that VA savings could be reinvested into VA, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,⁷³⁷ and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.⁷³⁸ These steps and congressional passage of legislation to reform health care eligibility laws paved the way for establishing universal primary care in VA and developing community-based clinics across the country.⁷³⁹

Sweeping Reform

During a 5-year period, Kizer dramatically changed almost every major VHA management system and improved operational performance through the use of performance measures and contracts. He closed nearly 29,000 acute care beds, merged 52 medical centers into 25 multi-campus facilities, reduced staffing by almost 26,000, opened more than 300 community-based outpatient clinics, and treated 24 percent more patients. In addition to bringing measurable quality into VA health care, Kizer achieved marked reductions in waiting times and medical errors.⁷⁴⁰

Kizer's tenure brought dramatically improved quality, service, and operational efficiency to VHA yet threatened powerful interests. As he noted, "...places like Florida, Arizona, and the

⁷³³ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 316, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁴ Ibid., 318-323.

⁷³⁵ VA in 2006 won the Harvard Innovations in Government Award for its VistA system. James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 211.

⁷³⁶ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 157-165.

⁷³⁷ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 323, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 128-129.

⁷³⁹ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 319-320, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷⁴⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 170.

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Sun Belt States were not getting their fair share [of funds] and their elected officials were unhappy about it. People from Pennsylvania and Illinois and New York were not about to give their money away, so there was this big disconnect.”⁷⁴¹ Kizer’s team developed a capitation system to more equitably allocate funds across the system. Aware of the political ramifications, he implemented incremental changes during a 2- to 3-year period to make them as painless as possible. But the congressional goodwill he had enjoyed unraveled when Kizer and his VISN directors began cutting and consolidating facilities to accommodate VISN funding cuts. The threat of hospital mergers and consolidations ultimately led several senators to block his confirmation to a second term.⁷⁴²

Under new eligibility reform law, all veterans became *eligible* for VA health care, though its authors did not envision that the system could or would serve all eligible individuals, or even all who might someday seek VA care. The law’s priority-based enrollment system was intended to give VA a tool to align demand for care with its funding level.⁷⁴³ The law instead unleashed political pressure to expand enrollment, opening the door to an influx of veterans who historically had not been VA health care users and many of whom were already covered under military retirement benefits, private insurance, or Medicare.⁷⁴⁴ That expansion led to a tremendous demand for prescription drug benefits by new enrollees and in 2003, Secretary Tony Principi ended enrollment for higher income (category 8) veterans “to keep the system solvent.”⁷⁴⁵ At about the same time, other related pressures led Principi to establish an advisory body, the Capital Asset Realignment for Enhanced Services (CARES) Commission, to develop a comprehensive capital asset plan. Principi cited the age of VA facilities and the changes in medical practice, but also reminded a congressional oversight committee of a 1999 Government Accountability Office finding that “maintaining obsolete or duplicative structures diverts \$1 million a day, every day, every year, away from the care of veterans.” Principi did not want to repeat Kizer’s experience and hoped to avoid political backlash.⁷⁴⁶

The CARES Commission released a final report in February 2004 that recommended relatively few actual facility closures, though it proposed substantial facility mission changes at a number of facilities.⁷⁴⁷ As the then USH later recounted, “CARES, like so many things in Washington, was well-intended, but it was derailed politically once it began moving toward actual targeted action within specific congressional districts.”⁷⁴⁸

Despite such defeats, Principi and VA under secretaries following Kizer met formidable challenges, left legacies, and saw the veterans’ health care system continue to be heralded for several years.⁷⁴⁹ A cascade of other events muddled, and even blackened, VHA’s reputation:

⁷⁴¹ Ibid., 133-134.

⁷⁴² Ibid., 168-169.

⁷⁴³ Veterans Affairs Comm., Veterans’ Health Care Eligibility Reform Act of 1996, H. R. Rep. No. 104-690 (1996), accessed June 3, 2016, <https://www.congress.gov/congressional-report/104th-congress/house-report/690/1>.

⁷⁴⁴ James Rife, *Not Your Father’s VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 193.

⁷⁴⁵ Ibid., 194.

⁷⁴⁶ Ibid., 195.

⁷⁴⁷ Ibid., 196.

⁷⁴⁸ Ibid.

⁷⁴⁹ “The Best Care Anywhere,” Phillip Longman, *Washington Monthly*, accessed June 3, 2016,

accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center (VAMC); failed software acquisitions;⁷⁵⁰ hard-hitting inspector general audit reports on issues such as system flaws, quality of care issues, and lack of timely care that fueled congressional oversight and other constraints. The 2014 scandal that erupted at the Phoenix VAMC represented a decisive turning point and set the stage once again for transforming veterans' health care.

Among initial steps on that long road to transforming the system, the Senate in July 2014 unanimously confirmed Robert A. McDonald, former chief executive officer of Proctor & Gamble, as secretary of veterans affairs. With a business career of delivering better results, McDonald, along with DEPSECVA Sloan Gibson and USH Dr. David Shulkin, has been working to improve VA's health care system and service delivery, and to set a framework for long-term reform. Days after McDonald's confirmation, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, omnibus legislation to improve veterans' access to care. This legislation established the *Choice Program*, mandated an independent assessment of VHA, and established the Commission on Care.

<http://www.washingtonmonthly.com/features/2005/0501.longman.html>. "Revamped Veterans Health Care Now a Model," Gilbert Gaul, accessed June 3, 2016, <http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html>. "The Best Medical Care in the U.S.: How Veterans Affairs Transformed Itself—and What it Means for the Rest of Us," Catherine Arnst, accessed June 3, 2016, <http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot>.

⁷⁵⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 216-217.

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APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY

Health care has evolved in major ways since the federal government began providing care to veterans after the Civil War, and it will continue to evolve substantially in the future. There are a number of factors that drive evolution in health care, such as population and lifestyle changes, changes within the various health care professions, medical and information systems technology, and systems changes in management and operations.⁷⁵¹ IBM Center for Applied Insight reports that there are 18 trends to watch in health care.⁷⁵² These trends closely encompass those highlighted below. The categories in which the trends fall mirror key topics addressed in the Commission's report to include data system interoperability (10 trends), consumer technology (two trends), health care providers (two trends), government regulations (two trends), and human resources and leadership (two trends). With health care changing so rapidly, and in so many different ways, it is imperative that veterans' health care continually evolve to remain aligned with current and future trends. This section highlights key trends that, based on past experience and current practice, will likely shape health care in the future, were considerations in formulating the Commission's recommendations, and will likely affect transformation of veterans' health care.

Emergence of Large Health Care Systems

The health care industry is moving away from stand-alone community hospitals that serve the needs of a local constituency to large, multiple-campus health care systems.⁷⁵³ The industry will see more high profile mergers and acquisitions in the second half of 2016.⁷⁵⁴ The December 2015 Health Research Institute's report indicates that well-known health care systems may have a market advantage as Americans are willing to travel further for care from a well-known system. This may explain the development and affiliation for Mayo Clinic in Arizona and Florida, and Cleveland Clinic opening in Florida. The report also states that although people are willing to drive for care they are not willing to pay prices higher than the local market. Because of increasing use of outpatient services and same-day surgery, facilities within these health care systems require fewer inpatient beds.⁷⁵⁵ With the advancement of psychotropic drugs, the perceived need for large mental hospitals has declined.⁷⁵⁶ Because of shorter recovery stays, increased outpatient services, telemetry and other monitoring programs, and new medical inventions, hospitals are now built as smaller facilities with parts or sections that can be quickly

⁷⁵¹ Lynn Etheredge, Stanley B. Jones, and Lawrence Lewin, "What is Driving Health System Change?" *Health Affairs*, 15, 4, (1996): 93-104.

⁷⁵² "Healthcare Internet of Things 18 Trends to watch in 2016," Bill Chamberlain, IBM Center for Applied Insights, March 1, 2016, accessed June 20, 2016, <https://ibmcai.com/2016/03/01/healthcare-internet-of-things-18-trends-to-watch-in-2016>.

⁷⁵³ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed April 29, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁵⁴ Ibid.

⁷⁵⁵ Ibid.

⁷⁵⁶ "How Release of Mental Patients Began," Richard Lyons, accessed May 1, 2016, <http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

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modified for future changes and medical advances.⁷⁵⁷ VHA will need to consider this trend in evaluating its current physical plant and planning for future facility needs.

Management Changes

As health care systems become increasingly complex, there is a need to manage these institutions using current management theories and models.⁷⁵⁸ During the past few decades, hospital and health care management changed from being managed by a traditional top-down model to continuous quality improvement models that respond to issues such as staff satisfaction, medication errors, safety matters, and wasteful use of supplies. To address errors, hospitals have implemented Six Sigma principles. To address waste, hospitals have implemented LEAN principles. Embracing these changes in management approach and implementing Six Sigma and LEAN principles will support VHA's transformational process.

Health Care Payment

The health care industry is in the midst of transforming its payment model away from a fee-for-service model to value-based payments, a system that drives improved health outcomes.⁷⁵⁹ This transformation is tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which health care experts expect to shape care delivery and payment reform across the U.S. health care system over the coming decades. Congress created MACRA as a transformative law to fast track the health care system's transition from a traditional fee-for-service payment model to new risk-bearing, coordinated care models.⁷⁶⁰ Because this legislation is still in rulemaking, it is premature for the Commission to weigh in on its potential effect on VA. The MACRA legislation expands the trend toward creation of accountable care organizations (ACOs) and bundled payments for care. ACO models have been reported to drive reduced hospitalization and generate cost savings.⁷⁶¹

Specialty Care Facilities

With changes in the federal payment for hospitals, some high-cost and longer-stay care treatments have been moving out of community hospitals to specialty hospitals. For example, long-term acute care hospitals primarily treat patients on ventilators; rehabilitation facilities treat short-term, post-acute patients who need primarily physical and occupational therapy services for orthopedic or stroke incidences; and cancer hospitals provide innovative treatments for Stage 4 cancer. As a result, community hospitals may no longer need beds to take care of these special patients. VHA will need to consider this trend in planning integrated care networks and evaluating its facility needs in conjunction with these networks.

⁷⁵⁷ "The Small Hospital of the Future," Shati Matambanadzo, accessed May 3, 2016, <http://www.healthcaredesignmagazine.com/article/small-hospital-future>.

⁷⁵⁸ "How to Solve the Cost Crisis in Health Care," Robert S. Kaplan and Michael E. Porter, accessed May 2, 2016, <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>.

⁷⁵⁹ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

⁷⁶⁰ "MACRA: Disrupting the health care system at every level," Deloitte, accessed June 23, 2016, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html>.

⁷⁶¹ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, Inquisitr: Medicine, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

Outpatient Care and Lifestyle-oriented Venues for Care

With improvements in surgical procedures, many surgeries that required post-surgery hospital stays are now routinely performed in outpatient settings.⁷⁶² Many nonsurgical procedures are being performed in outpatient clinics as well, such as medical imaging, cardiac catheterization, substance abuse treatment, gastrointestinal screening and cancer treatment.⁷⁶³ As care that was once provided only in hospitals is now provided in specialized medical clinics, care that was once provided only in physicians' offices is now being provided in alternative settings. As reported in Health Affairs, "another health care trend consumers are using to save both time and money is that rather than making appointments with their doctors, they are choosing to use walk-in clinics."⁷⁶⁴ Many of these clinics are located in pharmacies, retail chains, or supermarkets, allowing consumers quick, convenient, less-costly care.⁷⁶⁵ Do-it-yourself health care is also a trend, with increasingly more people taking responsibility for their health care. Consumers are using smart phone apps to monitor vital signs, medication adherence, and even urinalysis.⁷⁶⁶ As part of a commitment to continuous improvement, VHA will need to consider alternative venues as it creates integrated health care networks.

Medical Technology

Medical technology companies create life-changing innovation, and "advanced medical devices and diagnostics allow people to live longer, healthier and more productive lives."⁷⁶⁷ In fact, during the past 30 years, medical advancements helped add five years to U.S. life expectancy and reduce fatalities from heart disease, stroke, and breast cancer by more than half.⁷⁶⁸ These advancements also yield savings across the health care system by replacing more expensive procedures, reducing hospital stays, and allowing people to return to work more quickly.⁷⁶⁹ Ensuring veterans receive care that employs cutting-edge technology will be an important part of establishing integrated care networks.

Telemedicine

According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."⁷⁷⁰ Telemedicine includes a growing variety of applications and

⁷⁶² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

⁷⁶³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁶⁴ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

⁷⁶⁵ Ibid.

⁷⁶⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁶⁷ "Value of Medical Technology," Advanced Medical Technology Association, accessed May 2, 2016, <http://advamed.org/page/74/value-in-medical-technology>.

⁷⁶⁸ "Value of Medical Innovation," HealthCare Institute of New Jersey, accessed May 2, 2016, <http://hinj.org/value-of-medical-innovation/>.

⁷⁶⁹ Ibid.

⁷⁷⁰ "What is Telemedicine," American Telemedicine Association, accessed May 2, 2016, <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VwFrqfkrJaQ>.

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services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology. The use of telemedicine has spread rapidly and is now becoming integrated into hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces. The following are examples of how telehealth is being used:

- A specialist assisting the primary care physician in rendering a diagnosis might use interactive video or store-and-forward transmission of diagnostic images or information.
- Home-use devices might be used to remotely collect information such as vital signs, blood glucose, or heart electrocardiogram data and transfer it in real time to a home health agency or a remote diagnostic testing facility for interpretation.
- Consumers' internet and wireless devices might be used to obtain specialized health information or participate in online peer-to-peer support groups.

VHA already excels in the use of telehealth and should expand upon its work in this area.

Midlevel Practitioners

During the past few decades, new categories of health care professionals have become increasingly commonplace in hospital settings. For example, hospitalists, physicians who specialize in the practice of hospital medicine, take over when the community-based physician admits his/her patient to the hospital.⁷⁷¹ The hospitalist does not perform the surgery but rather takes on the monitoring of the hospital services needed by the patient. Another example is medical technicians, who monitor the specialized medical equipment and devices that previously were under the purview of nurses in specialty units such as intensive care units. The growing physician shortage has led to reliance on mid-level health care providers. According to the Centers for Medicare and Medicaid Services' National Provider Identifier dataset, there were approximately 106,000 practicing nurse practitioners and 70,000 practicing physician assistants in 2010.⁷⁷² Provider trends may play into ways VHA can address its current staffing shortage.

Electronic Patient Health Information

Health records have undergone transformation from free-form physician notes of the 17th century to electronic health records (EHRs) of the 21st century. Today, providers are using clinical applications such as computerized physician order entry systems; EHRs; and radiology, pharmacy, and laboratory systems to track patient care and progress. Health plans are providing access to claims and care management, as well as member self-service applications.⁷⁷³ These advances allow the medical workforce to be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are). Though their use comes with

⁷⁷¹ "Definition of a Hospitalist and Hospital Medicine," Society of Hospital Medicine, accessed May 2, 2016, http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx.

⁷⁷² "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States," Agency for Healthcare Research and Quality, accessed May 2, 2016, <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html>.

⁷⁷³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

inherent potential security and privacy risks, they will surely play a substantial role in shaping future health care.⁷⁷⁴ Interoperability of these sources of patient information will be a continuing key issue in private-sector, military, and veterans' healthcare organizations.

Population Health

Population health refers to considering incidence and prevalence of diseases in a given area to determine if the area or the environment is contributing to the illness. Physicians and other health care providers may look at a region's demographics to determine what types of care are needed within the population. For example, if 65 percent of the region is older than age 65, then a series of wellness programs that address the chronic care concerns of this population may be needed. From a population health perspective, communities and their respective populations are as important as the individual patients who comprise them when it comes to keeping residents healthy. For VHA, population health issues may revolve around populations of veterans who served in particular wars and operations and the respective injuries and illnesses associated with them.

Geriatric Care

In the United States and Western Europe the birth rate has slowed⁷⁷⁵ and people are living longer.⁷⁷⁶ Demographic researchers report that if an American makes it to age 65, he/she should have about 17 to 20 additional years of life.⁷⁷⁷ Nursing homes and assisted living facilities are now seeing increasingly more of residents' first-time admissions occurring at age 80 or older. Some congregate care retirement facilities report that even with admission in the 80s, the average life expectancy is another 12 or 13 years.⁷⁷⁸ The aging population accounts for increasingly more hospital admissions, and as a result, hospitals rely on more revenue from Medicare.⁷⁷⁹ The VHA beneficiary population mirrors the general U.S. population, and older veterans receiving care through VHA may be sicker than their private-sector counterparts.

Chronic Disease Care

Chronic conditions now account for more than 50 percent of the death rate. Acute problems had previously been the primary causes of death.⁷⁸⁰ Even HIV/AIDS has moved away from being considered an immediate death sentence, and now, with proper treatment, is considered by

⁷⁷⁴ "Summary of the HIPAA Privacy Rule," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/>.

⁷⁷⁵ "Fact Sheet: The Decline in U.S. Fertility," Mark Mather, accessed May 2, 2016, <http://www.prb.org/publications/datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx>.

⁷⁷⁶ National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/abus15.pdf>.

⁷⁷⁷ National Center for Health Statistics, *Life Expectancy at Birth, at Age 65, and at Age 75, by Sex, Race, and Hispanic Origin: United States, Selected Years 1900-2010*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/2011/022.pdf>.

⁷⁷⁸ Kathleen Harris, *CCRC Resident Demographics and Health Care Utilization: An Analysis*, accessed May 3, 2016, <http://www.avpowell.com/docs/Fall1997.pdf>.

⁷⁷⁹ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁸⁰ "Chronic Disease Overview," Centers for Disease Control and Prevention, accessed May 2, 2016, <http://www.cdc.gov/chronicdisease/overview/>.

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most to be a chronic disease.⁷⁸¹ The Centers for Disease Control reports that since 2014, more Americans are dying as a result of chronic conditions and diseases than from acute diseases. Most chronic diseases result from lifestyle choices. Lifestyle diseases result from choices that individuals make.⁷⁸² Health care systems invest resources in addressing lifestyle-related issues caused by behaviors such as smoking, using opiates, and overeating.⁷⁸³ Lifestyle diseases such as cancer caused by smoking, addiction caused by drug use, and diabetes caused by obesity, are costly to treat.⁷⁸⁴ Because lifestyle diseases change over time, they are important to consider in thinking about the future of veterans' healthcare. Treating chronic diseases can be costly because care is ongoing, and assuming this trend continues to become more prominent, it will affect the cost of care and how it is provided.⁷⁸⁵

Needs-based Health Care

The Affordable Care Act requires all not-for-profit hospitals to complete a survey of the community (community health needs assessment, or CHNA) to show what entities in the community will address identified needs (asset mapping) and then report on how the hospital will address these needs in a community health care implementation program (CHIP).⁷⁸⁶ Starting in 2016, hospitals must post these reports on their websites and conduct these evaluations every 3 years thereafter. Monitoring community health needs can lead to preventing or stopping the spread of disease. For example, scarcity of quality food has been documented to result in poor school attendance and increased illness.⁷⁸⁷ Some Americans simply have not been exposed to how to prepare vegetables and fruits because they live in areas that are called *food deserts*, where healthy foods are not readily available. Identifying such needs and how they will be addressed can help improve health for specific populations.⁷⁸⁸ In Washington, DC, such a health assessment led to new treatments and protocols for addressing the appearance of a rare strain of tuberculosis brought in by a group of legal immigrants.⁷⁸⁹ Using CHNA and CHIP could be part of VHA's ongoing planning process.

⁷⁸¹ Steven G. Deeks, Sharon R. Lewin, and Diane V. Havlir, "The End of AIDS: HIV Infection as a Chronic Disease," *Lancet*, 382, 9903, (2013): 1525-1533.

⁷⁸² "Lifestyle Choices: Root Causes of Chronic Diseases," Cleveland Clinic, accessed May 2, 2016, https://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases.

⁷⁸³ D. B. Resnik, "Responsibility for Health: Personal, Social, and Environmental," *Journal of Medical Ethics*, 33, 8, (2007): 444-445.

⁷⁸⁴ "How to Save a Trillion Dollars," Mark Bittman, accessed May 2, 2016, <http://opinionator.blogs.nytimes.com/2011/04/12/how-to-save-a-trillion-dollars/>.

⁷⁸⁵ "Why We Need Public Health to Improve Healthcare," National Association of Chronic Disease Directors, accessed May 2, 2016, <http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC>.

⁷⁸⁶ "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act," Internal Revenue Service, accessed May 2, 2016, <https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act>.

⁷⁸⁷ "Hunger In Our Schools: Breakfast Is A Crucial 'School Supply' For Kids In Need," Tom Nelson, accessed May 2, 2016, <http://blogs.usda.gov/2015/03/03/hunger-in-our-schools-breakfast-is-a-crucial-school-supply-for-kids-in-need/>.

⁷⁸⁸ "The Capital's Food Deserts," Jeremy Moorhead, accessed May 3, 2016, <http://eatocracy.cnn.com/2012/03/14/the-capitals-food-deserts/>.

⁷⁸⁹ District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB (HAHSTA) Annual Report: 2010*, accessed May 3, 2016, http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2010_Annual_Report_FINAL_0_0.pdf.

Behavioral Health

Treatment for mental health, now more commonly referred to as behavioral health, has changed dramatically since a 1968 federal law required individuals be cared for in the least restrictive environment.⁷⁹⁰ This law led to an expectation that most patients would receive care in out-patient facilities. Recently legislation was passed that requires insurance companies to increase the amount of payment for behavioral health, which could add more patients to the health care system.⁷⁹¹ VHA is a leader in mental health treatment and should continue to be a trendsetter in this regard.

Preventive Medicine

Traditionally, physicians were trained to cure illness and to restore the sick to health. The trend, however, is changing, and physicians are now trained in prevention and are more active participants in the prevention of illness.⁷⁹² Additionally, insurance and Medicare now cover preventive care and annual physicals, further supporting prevention.⁷⁹³ Preventive medicine is a key component of integrated health care and will need to be considered as VHA works to transform veterans' healthcare.

Pharmacy Changes

Health Affairs reports that "in 2015 . . . an alarming trend of new high-cost specialty pharmaceuticals entered the market. . . . Overall drug spending increased 12.2 percent last year, the highest rate of increase in more than a decade."⁷⁹⁴ Escalating drug prices account for some of this increase, including more than 3,500 generic drugs that at least doubled in price from 2008–2015 and about 400 drugs that increased in cost 1000 percent.⁷⁹⁵ Newly emerging and very expensive developments in the area of genomic medication also contribute to the increase. "One way to combat skyrocketing prices will be biosimilar drugs. These drugs are near substitutes for original brand drugs and could bring significant price discounts."⁷⁹⁶ Because many of VHA's beneficiaries seek only prescription benefits, prescription drug trends will be important to consider in the transformation process.

⁷⁹⁰ "How Release of Mental Patients Began," Richard Lyons, accessed May 2, 2016,

<http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

⁷⁹¹ "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," Substance Abuse and Mental Health Services Administration, accessed May 2, 2016, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

⁷⁹² "Opinion 8.075 – Health Promotion and Preventive Care," American Medical Association, accessed May 2, 2016, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8075.page>.

⁷⁹³ "Preventive Services Covered Under the Affordable Care Act," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/>.

⁷⁹⁴ Anne Martin et al., "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," *Health Affairs*, 35, 1, (2016): 150-160.

⁷⁹⁵ "Generic Drug Prices Quickly on the Rise," Anthony L. Komaroff, accessed May 2, 2016, <http://www.spokesman.com/stories/2016/feb/18/generic-drug-prices-quickly-on-the-rise/>.

⁷⁹⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

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APPENDIX F:

THE COMMISSION'S PROCESS

Commission Meetings

From September 2015 to June 2016, the Commission held convened 12 sessions of public meetings (26 days). The content addressed at each meeting is listed in the following table.

September 21-22, 2015

Assessment A: Demographics	RAND Corporation <ul style="list-style-type: none"> Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation <ul style="list-style-type: none"> Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Bob McDonald, Secretary Sloan Gibson, Deputy Secretary David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation <ul style="list-style-type: none"> Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP <ul style="list-style-type: none"> Lane Jackson Aamir Syed Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Alex Harris Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP <ul style="list-style-type: none"> Peter Erwin, PhD Hillary Peabody Erik Shannon
Assessment J: Supplies	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Robin Roark, MD
Assessment K: Facilities	McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg John Means

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September 21-22, 2015 (continued)

VHA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
Assessment Leadership	CMS Alliance to Modernize Health care <ul style="list-style-type: none"> Stephen Kirin Jay Schnitzer, PhD, MD McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg
Assessment H: Health IT	MITRE Corporation <ul style="list-style-type: none"> Aparna Durvasula Glenn Himes McKinsey & Company <ul style="list-style-type: none"> Celia Huber Vivian Riefberg

October 6, 2015

Eligibility	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State	Veterans Health Administration <ul style="list-style-type: none"> Stephanie Mardon, Chief Business Officer Kristin Cunningham, Director, Business Policy Affairs
Future State of VA Community Care/ Care in the Community	Veterans Health Administration <ul style="list-style-type: none"> Joe Dalpiaz, Director, VISN 17 Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs Gene Migliaccio, Deputy Chief Business Officer, Managed Care
Academic Affiliations	Veterans Health Administration <ul style="list-style-type: none"> Robert Jesse, MD, Chief, Office of Academic Affiliations Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015

Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion	<ul style="list-style-type: none"> ▪ Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE ▪ Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America
Women's Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ David Carroll, Executive Director, Mental Health Operations ▪ Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration <ul style="list-style-type: none"> ▪ Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine <ul style="list-style-type: none"> ▪ Michael McGinnis, MD ▪ Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council <ul style="list-style-type: none"> ▪ Ken Mullins
Scheduling	Veterans Health Administration <ul style="list-style-type: none"> ▪ Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Bob Snyder, Executive Director, MyVA Task Force ▪ Tom Muir, Director, Support Services

November 16–17, 2015

Health Care Economics/Finance	<ul style="list-style-type: none"> ▪ Mark Yow, Acting Chief Financial Officer, VHA ▪ Paul Mango, McKinsey & Company ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges <ul style="list-style-type: none"> ▪ Atul Grover, PhD, MD, Chief Public Policy Officer ▪ John E. Prescott, MD, Chief Affiliations Officer ▪ Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration <ul style="list-style-type: none"> ▪ Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services ▪ Donna Gage, PhD, RN, Chief Nursing Officer

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December 14-16, 2015

Minority Affairs and Health Equity	Department of Veterans Affairs <ul style="list-style-type: none"> Barbara Ward, Director, Center for Minority Affairs Veterans Health Administration <ul style="list-style-type: none"> Uchenna S. Uchendu, MD, Executive Director, Office of Health Equity
Framework for the Future of Veterans Health	<ul style="list-style-type: none"> Garry Augustine, Disabled American Veterans Carl Blake, Paralyzed Veterans of America Carlos Fuentes, Veterans of Foreign Wars Ray Kelley, Veterans of Foreign Wars
Veteran Service Organizations	<ul style="list-style-type: none"> Louis Celli, The American Legion Renee Campos, Military Officers Association of America
National Health Information Operability	<ul style="list-style-type: none"> Dr. Jon White, Deputy National Coordinator, Department of Health and Human Services
DoD I Procurement: Lesson Learned/Interagency Program Office	<ul style="list-style-type: none"> Chris Miller, Program Executive Officer, Defense Health Care Management Systems, Department of Defense
Health Information Exchange	<ul style="list-style-type: none"> Elaine Hunolt, Do-Director Interoperability Office, Veterans Health Administration Dr. Harry Leider, Chief Medical Officer, Walgreens James Wood, VP-Federal, Walgreens Mariann Yeager, Chief Executive Officer, The Sequoia Project
Vision for OI&T/Collaboration with VHA	<ul style="list-style-type: none"> LaVerne Council, Chief Information Officer, Department of Veterans Affairs
Leadership and Transformation	<ul style="list-style-type: none"> Charles Rossotti, Former Commissioner, Internal Revenue Service

January 19 and 21, 2016

VHA Leadership	<ul style="list-style-type: none"> Dr. Michael Kussman, former Undersecretary for Health, Veterans Health Administration Dr. Kenneth Kizer, former Undersecretary for Health, Veterans Health Administration
Labor Perspectives	American Federal of Government Employees <ul style="list-style-type: none"> Marilyn Park National Association of Veterans Affairs Physicians and Dentists <ul style="list-style-type: none"> Samuel Spagnolo Nurses Organization of Veterans Affairs <ul style="list-style-type: none"> Joan Clifford Sharon Johnson

January 19 and 21, 2016 (continued)

Behavioral Health	<ul style="list-style-type: none"> Association of Veterans Affairs Psychologist Leaders <ul style="list-style-type: none"> Thomas Kirchberg Russell Lemle Edgardo Padin-Rivera Antonette Zeiss American Psychiatric Association <ul style="list-style-type: none"> Jenny L. Boyer Association of Veterans Affairs Social Workers <ul style="list-style-type: none"> LeAnn Bruce Jerry Satterwhite
Homeless Veterans	<ul style="list-style-type: none"> Keith Armstrong, San Francisco Veterans Affairs Health care System
Other-Than-Honorable Discharges	<ul style="list-style-type: none"> Branford Adams

February 8-9, 2016

Construction Management	<ul style="list-style-type: none"> Lisa Freeman, Medical Center Director, Palo Alto Health care System
VISN and Field Leadership Perspectives	<ul style="list-style-type: none"> Joleen Clark, Former Network Director, VISN 8 Jon Gardner, Former Medical Center Director, Tucson VA Medical Center Lisa Freeman, Medical Center Director, Palo Alto Health care System
Implementation of the <i>Choice Program</i>	<ul style="list-style-type: none"> Billy Maynard, President HealthNet Federal Service David J. McIntyre, Jr., President and Chief Executive Officer, TriWest Healthcare Alliance
Update on VHA	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health, Veterans Health Administration
Determining Feasibility	<ul style="list-style-type: none"> Patrick Ryan, Former Staff Director and Chief Counsel, House Veterans Affairs Committee

February 29 – March 1, 2016

Economist Briefing	<ul style="list-style-type: none"> Gideon Lukens, PhD, Staff Economist Jamie Taber, PhD, Staff Economist
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March 21-23, 2016

Conversation with HVAC Chairman	<ul style="list-style-type: none"> Rep. Jeff Miller (R-FL)
Conversation with HVAC Member	<ul style="list-style-type: none"> Rep. Beto O'Rourke (D-TX)
Veterans Health Administration	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health Barbara Manning, Office of Policy and Planning Lyn Stoesen, Office of Policy and Planning

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March 21-23, 2016 (continued)

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Merideth Randles, FSA, MAAA, Milliman, Inc.
- Jamie Taber, PhD, Staff Economist

April 18-19, 2016

Veterans Service Organizations

- Garry Augustine, Disabled American Veterans
- Peter Dickinson, Disabled American Veterans
- Verna Jones, American Legion
- Rick Weidman, Vietnam Veterans of America
- Bill Rausch, Got Your 6
- Ray Kelley, Veterans of Foreign Wars
- Rene Campos, Military Officers Association of America

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

VA Leadership

Department of Veterans Affairs

- Bob McDonald, Secretary
- Sloan Gibson, Deputy Secretary

Community Care

- Baligh Yehia, MD, Assistant Deputy Under Secretary for Community Care, VHA

May 9-11, 2016

VA Office of General Counsel

- Leigh Bradley, General Counsel
- Jessica Tanner, Staff Attorney

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

June 7-8, 2016

No speakers

Commission Workgroups

The Commission on Care organized itself into workgroups in order to complete an analysis of relevant issues, consider options, and suggest recommendations to the full Commission for debate. The Commission formed five workgroups with each responsible for sections of the Independent Assessment or other topics taken on by the group. In establishing each workgroup an effort was made to balance perspectives and expertise, although Commissioners expressed interests were also taken into account in forming the membership of each group. The membership of each workgroup and the topics taken on by each is summarized in Table F-1.

Table F-1. Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP	
Health Care Alignment	<ul style="list-style-type: none"> ▪ Demographics ▪ Health care Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance 	<ul style="list-style-type: none"> ▪ Blecker ▪ Johnson ▪ Longman ▪ Selnick 	<ul style="list-style-type: none"> ▪ Gorman ▪ Khan ▪ McClenney
Health Care Operations	<ul style="list-style-type: none"> ▪ Access Standards ▪ Workflow Scheduling ▪ Workflow Clinical ▪ Staffing Productivity 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Harvey ▪ Longman ▪ Webster 	<ul style="list-style-type: none"> ▪ Gorman ▪ Hickey ▪ Taylor
Health Care Data, Tools & Infrastructure	<ul style="list-style-type: none"> ▪ Health IT ▪ Business Processes ▪ Supplies ▪ Facilities 	<ul style="list-style-type: none"> ▪ Blom ▪ Harvey ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Johnson ▪ Taylor
Health Care Leadership	<ul style="list-style-type: none"> ▪ Organizational Health ▪ Leadership Systems 	<ul style="list-style-type: none"> ▪ Blecker ▪ Hickey ▪ Selnick ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ McClenney ▪ Schlichting
Health Care Trends	<ul style="list-style-type: none"> ▪ Market Trends ▪ Technology ▪ Financing ▪ Vision 	<ul style="list-style-type: none"> ▪ Blom ▪ Johnson ▪ Schlichting 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Khan ▪ Webster

Each workgroup, together with any staff assigned to it, reviewed the findings and recommendations of the Independent Assessment and the Integrated Report; investigated external benchmarks and best practice models; heard testimony in public meetings (with the full Commission); met in workgroup session with VA employees, leaders, former staff and external experts to gather additional insights and explore relevant questions. Commissioners reviewed white papers and strawman proposals prepared by staff and by one another. Based on the assessments and group deliberations, each workgroup developed recommendations for consideration by the full Commission. Details of the process and outputs from each workgroup are described in the following sections.

COMMISSION ON CARE FINAL REPORT

Health Care Alignment Workgroup

The alignment workgroup organized its work around six main topics: governance, realignment of facilities and services, medical sharing, eligibility, other than honorable discharges, and the organization of provider networks. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic was introduced through a summary paper or summary points which then were used as the basis for a conference call or a face-to-face discussion. For most topics, subsequent calls were held to discuss more detailed papers or to re-visit outstanding issues not yet resolved.

Commissioners also reviewed draft papers and provided additional feedback, revisions, and comments through written comments. The papers were finalized for inclusion in the draft Commission report for discussion on April 19. A summary of the work completed on each topic is provided in the table below.

Table F-2. Alignment Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Governance	11/17/2015	M	Vivian Riefberg	9/22/2015	F
	1/7/2016	C	Stephen Kirin	9/22/2015	F
	1/28/2016	C	Jay Schnitzer	9/22/2015	F
	2/18/2016	C	Paul Light	10/30/2015	S
	3/3/2016	C	Charles Rossotti	12/16/2015	F
	3/10/2016	C	Michael Kussman	1/19/2016	F
	3/17/2016	C	Ken Kizer	1/19/2016	F
	4/7/2016	C	Jeff Miller	3/21/2016	F
Realignment of Facilities and Services	1/7/2016	C	Vivian Riefberg	9/22/2015	F
	1/28/2016	C	John Means	9/22/2015	F
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Medical Sharing	1/28/2016	C	Atul Gover	11/16/2015	F
	3/3/2016	C	John Prescott	11/16/2015	F
	3/10/2016	C	Mathew Schick	11/16/2015	F
	3/17/2016	C			
	4/7/2016	C			
Eligibility	11/17/2015	M	Christine Eibner	9/21/2015	F
	12/10/2015	C	Michael Greenberg	9/21/2015	F
	1/28/2016	C	Pat Vandenberg	9/21/2015	F
	2/25/2016	C	Stephenie Mardon	10/6/2015	F
	3/10/2016	C	Kristin Cunningham	10/6/2015	F
	3/17/2016	C	Gail Wilensky	10/19/2015	F
	4/7/2016	C	Michael McGinnis	10/20/2015	F
			Marianne Hamilton Lopez	10/20/2015	F
			Michael Kussman	1/19/2016	F
			Jeff Miller	3/21/2106	F

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Other-Than-Honorable Discharge	1/28/2016	C	Bradford Adams	1/20/2016	F
	2/18/2016	C			
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Organization of Provider Networks	1/28/2016	C	Peter Hussey	9/21/2015	F
	2/25/2016	C	Joe Dalpiaz	10/6/2015	F
	3/10/2016	C	Baligh Yehia	10/6/2015	F
	3/17/2016	C	Gene Migliaccio	10/6/2015	F
	4/7/2016	C	Michael Kussman	1/19/2016	F
			Jon Gardner	2/8/2016	F
			Billy Maynard	2/8/2016	F
			David McIntrye	2/8/2016	F
			Jeff Miller	3/21/2016	F
			Beto O'Rourke	3/22/2016	F

Health Care Operations Workgroup

The health care operations workgroup was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The workgroup (select Commissioners and support staff) first met face-to-face on October 7, 2015 to: introduce the staff, review guiding principles and business rules, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics was discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research on the four main topics; and cover other issues that may have come up during sessions (i.e., Best Practices) or from questions posed by Commissioners. To supplement the Commission conferences, the workgroup held teleconferences to cover additional research or present information from subject matter experts or emailed informational briefs and write-ups for review before a workgroup teleconference. Feedback from the Commissioners was addressed and the potential recommendations were refined. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

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Table F-3. Health Care Operations Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Access Standards	10/20/2015	M	Stephanie Mardon	10/6/2015	F
	12/3/2015	C	Kristin Cunningham	10/6/2015	F
	2/25/2016	C	Institute of Medicine	10/13/2015	S
	4/27/2016	C	Institute of Medicine	10/20/2015	F
Scheduling	10/7/2015	M	McKinsey Co	9/22/2015	F
			Stephanie Mardon	10/6/2015	F
			Kristin Cunningham	10/6/2015	F
			Dr. Michael Davies	10/14/2015	S
			Gary Monder	10/14/2015	S
			Steve Green	10/14/2015	S
			Michael McGinnis	10/14/2015	S
			Ken Mullins	10/14/2015	S
			Marianne Hamilton Lopez	10/14/2015	S
			Institute of Medicine	10/20/2015	F
			Dr. Michael Davies	10/20/2015	F
			Dr. Michael Davies	11/18/2015	W
Clinical Workflow	10/27/2015	C	McKinsey & Co.	9/22/2015	F
	2/18/2016	C	Nora Socci	12/29/2015	S
	4/6/2016	C	Diane Pulphus	2/3/2016	S
			Hugh Scott	2/26/2016	S
Staffing	11/4/2015	C	McKinsey Co	9/22/2015	F
	12/3/2015	C	Dr. Jonathan Perlin	10/19/2015	F
	1/20/2016	M	Barbara Ward	12/7/2015	S
	2/18/2016	C			
	2/25/2016	C			
	4/6/2016	C			
Productivity	12/15/2015	M	McKinsey Co	9/22/2015	F
			Gene Migliaccio	10/6/2015	F
			Boston VAMC	12/7/2015:	S
			Dr. Michael Charness		
			Melanie Gilhern		
			Meredith Walker		
Best Practices	1/6/2016	C	Dr. Melanie Vielhauer		
			Rosemary Conlon		
	1/6/2016	C	McKinsey Co	9/22/2015	F
	1/20/2016	M	Dr. Theresa Cullen	12/2/2015	W
	2/25/2016	C	Dr. Daniel Bochicchio	12/3/2015	S
	3/14/2016	E	David Atkins	1/5/2016	S
			Linda Lipson	1/5/2016	S
			Amy Kilbourne	1/5/2016	S
			Bob Monte	1/5/2016	S
			Rachel Goffman	1/5/2016	S
			Dr. Daniel Bochicchio	1/20/2016	S
			Barbara Meadows	2/25/2016	W
			Barbara Meadows	3/17/2016	W

Health Care Data, Tools & Infrastructure Workgroup

The Health Care Data, Tools & Infrastructure (DTI) workgroup organized its work around four main topics: Health Information Technology, Business Processes, Supplies and Facilities. DTI first met face to face on October 7, 2015 to: introduce the staff, review the charge of DTI, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics were discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research via white papers on the four main topics; and cover other issues that may have come up during sessions or from questions posed by Commissioners. To supplement the Commission face-to-face meetings, the workgroup held teleconferences to cover additional research or present information from subject matter experts. Feedback from the Commissioners was incorporated into the white papers and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-4. Data, Tools & Infrastructure Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call		S=met with staff		
	E= email review		W=met with workgroup		
	M= face-to-face meeting		F=full Commission testimony		
	Date	Type	Expert	Date	Type
Health IT	10/7/2015	M	MITRE Co	9/22/2015	F
	11/18/2015	C	Dr. Brett Giroir	10/19/2015	S
	12/2/2015	C	LaVerne Council,	10/27/15	HVAC
	3/7/2016	C	Chris Miller, Brian Burns		Hearing
	3/14/2016	C	Brookings Institution	11/6/2015	S
	3/21/2016	M	LaVerne Council	11/25/2015	S
	4/4/2016	C & E	Dr. Theresa Cullen	12/2/2015	W
			Chris Miller	12/15/2015	F
			Chuck Hume	12/15/2015	F
			Elaine Hunolt	12/15/2015	F
			Jim Wood	12/15/2015	F
			Mariam Yeager	12/15/2015	F
			LaVerne Council	12/15/2015	F
			Jamie Bennett	3/2/2016	S
			Margaret Donahue	3/11/2016	S
			Kai Miller	4/12/2016	S
Business Processes	10/20/2015	M	SecVA Bob McDonald	9/21/2015	F
	10/26/2015	M			
	3/14/2016	C			
	3/21/2016	M			
	4/4/2016	C			

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Supplies (Pharmaceutical & Medical Devices)	10/7/2015	M	McKinsey Co	9/21/2015	F
	10/26/2015	M	Jonathan Miller	12/4/2015	S
	2/23/2016	E	Tucker Taylor	12/4/2015	S
	2/24/2016	C			
	3/7/2016	C			
	3/14/2016	C			
	3/21/2016	M			
Facilities	10/7/2015	M	Bob McDonald	9/21/2015	F
	11/18/2015	M	Jim Sullivan	11/11/2015	S
	12/2/2015	C	Mark W. Johnson	12/21/2015	S
	12/22/2015	M	Kyle Reinhardt	12/22/2015	S
	2/16/2016	E	Thom Kurmel	12/22/2015	S
	2/17/2016	C	Rick Bond	12/22/2015	S
	2/24/2016	C & E	John Bulick	12/22/2015	S
	3/7/2016	C	John Kay	12/22/2015	S
	3/14/2016	C	Jim Sullivan	2/16/2016	S
	3/21/2016	M	Ed Bradley	2/16/2016	S
	4/4/2016	C	Jim Sullivan	2/17/2016	W
	4/11/2016	C	Jim Sullivan	3/15/2016	S
	4/27/2016	C			
Other	11/5/2015	E			
	11/6/2015	E			
	3/11/2016	E			

Health Care Leadership Workgroup

The leadership workgroup organized its work around five main topics: organizational health and cultural transformation and four leadership system issues: recruitment, retention, development and advancement; organizational structure and function; performance management and performance measurement; and human capital management. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic received an evidence review and summary which was the basis for a conference call or a face-to-face discussion. On a few topics, Commissioners or staff heard directly from VA staff or outside experts to inform the deliberation. Then, in a second meeting on the topic, the Commissioners debated a strawman proposal and alternative recommendations based on the evidence review and the prior Commission discussion. Feedback from the Commissioners was incorporated into the strawman and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. The papers were finalized and presented to the full Commission for deliberation and feedback on March 22, 2016. A summary of the work completed on each topic is provided in the table below.

APPENDIX F
THE COMMISSION'S PROCESS

Table F-5. Leadership Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Organizational Health and Cultural Transformation	12/2/2015	C	Stephen Kirin	9/23/2015	F
	12/9/2015	C	Jay Schnitzer	9/23/2015	F
	2/9/2016	M	Vivian Riefberg	9/23/2015	F
	2/17/2016	C	Dee Ramsel	11/9/2015	S
	3/11/2016	E	Ashby Sharpe	11/9/2015	S
			Ken Berkowitz	11/9/2015	S
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
Recruitment, Retention, Development, and Advancement	11/17/2015	M	Stephen Kirin	9/23/2015	F
	11/25/2015	C	Jay Schnitzer	9/23/2015	F
	2/17/2016	C	Vivian Riefberg	9/23/2015	F
	2/24/2016	C	Volney Warner	11/9/2015	S
	3/9/2016	C	Lisa Red	11/17/2015	W
	3/11/2016	E	Payton Rica-Lewis	11/17/2015	W
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Georgia Coffey	2/22/2016	S
			David Perry	2/24/2016	S
			Audrey Oatis-Newsome	2/24/2016	S
Organizational Structure and Function	10/27/2015	C	Stephen Kirin	9/23/2015	F
	2/9/2016	M	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Charles Rossotti	12/16/2015	F
			Michael Kussman	1/19/2016	F
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Robin Hemphill	3/4/2016	S
Performance Management and Performance Measurement	11/4/2015	C	Stephen Kirin	9/23/2015	F
	11/12/2015	C	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Peter Almenoff	10/30/2015	S
			Joe Francis	1/8/2016	S
			Carolyn Clancy	1/8/2016	S
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Noel Baril	3/9/2016	S

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WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Human Capital Management	12/15/2015	M	Stephen Kirin	9/23/2015	F
	12/23/2015	C	Jay Schnitzer	9/23/2015	F
	3/11/2016	E	Vivian Riefberg	9/23/2015	F
			Sam Retherford	12/15/2015	W
			Joleen Clark	2/8/2016	F
Leadership Vision	1/6/2016	C			
	1/21/2016	M			
	2/3/2016	C			
	2/4/2016	E			
Leadership Pre-amble	3/14/2016	E			

Site Visits

Background

In the coming decades there will be increased demand for accountability in health care and increased emphasis on health care outcomes and measurements, and VHA will need to rise to meet these expectations to survive and remain competitive in the demanding and turbulent health care environment.⁷⁹⁷ The changing nature of health care organizations, including pressure to reduce costs, improve the quality of care, and meet stringent guidelines, has forced health care professionals to reexamine how they evaluate performance.⁷⁹⁸ Although many health care organizations have long recognized the need to look beyond financial measures when evaluating performance, many still struggle with what measures to select and how to use the results of those measures.⁷⁹⁹

As the nation's largest health care system in 2016, VHA employs more than 305,000 health care professionals and support staff at more than 1,000 sites of care, including hospitals, community-based outpatient clinics (CBOCs), nursing homes, domiciliaries, and 300 Vet Centers.⁸⁰⁰ Given the scope of this health care system, the Commission recognized the importance of direct lines of communication and interaction with VHA leaders, staff, and patients, to include conducting facility site visits. Commissioners conducted facility site visits to their local VA facilities to assist in the evaluation of the findings identified by the *Independent Assessment Report*, to contribute to an environmental scan of the VHA, and to inform the development of recommendations.⁸⁰¹

Scope of Site Visits

In January and February 2016, most of the 15 Commissioners conducted site visits to the VA medical centers (VAMCs) and CBOCs proximal to their respective residences. The Commissioners approached these site visits with a collaborative and information-seeking tone with the purpose of having open discussions with VAMC leadership, staff, and patients.

Individual Commissioners visited 12 VAMC facilities or CBOCs in 7 out of 19 Veteran Integrated Service Networks (VISNs). Additionally, all the Commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

⁷⁹⁷ Kenneth W. Kizer, M.D., M.P.H./Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation for the Veterans Healthcare System*, accessed March 1, 2016, <http://www.va.gov/healthpolicyplanning/rxweb.pdf>.

⁷⁹⁸ Kicab Castaneda-Mendez/Quality Digest, Performance Measurement in Health Care, accessed, March 1, 2016, <http://www.qualitydigest.com/magazine/1999/may/article/performance-measurement-health-care.html#>.

⁷⁹⁹ Ibid.

⁸⁰⁰ Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, <http://vawww.usv.va.gov/>.

⁸⁰¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, v, accessed March 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

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Table F-6. VA Facility Site Visit Locations

VISN	VISN Name	VA Facility
2	VISN 2	VA Hudson Valley Health Care System (Montrose, NY)
6	VA Mid-Atlantic Health Care Network	Fredericksburg Community-based Outpatient Center, (Fredericksburg, VA)- part of Hunter Holmes McGuire VA Medical Center, Richmond, VA
7	VA Southeast Network	Ralph H. Johnson VA Medical Center (Charleston, NC) Wm. Jennings Bryan Dorn VA Medical Center (Columbia, SC)
10	VA Health Care System	VA Ann Arbor Health care System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Health care System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Health Care Network	Greater Los Angeles Health care System (Los Angeles, CA) VA San Diego Health care System (San Diego, CA)

The Commissioners were provided with a generic basic agenda as guidance, though they had the latitude to determine their own agendas as appropriate for the locations they visited. The model agenda included the following activities: a welcome and overview of the VA health care facility; tour of the facility; veteran discussion session (informal or formal); VHA employee session (e.g., informal or small group discussion); a discussion with the facility leadership, and were provided the recommended questions listed below:

- What does the medical center do well?
- What unique resources can the medical center draw on?
- What do others see as the strengths of the medical center?
- What could the medical center improve?
- Where does the medical center have fewer resources than others?
- What are others likely to see as weaknesses of medical center?
- What opportunities are open to the medical center?
- What trends could the medical center take advantage of?
- How can the medical center turn its strengths into opportunities?
- What threats could harm the medical center?
- What obstacles does the medical center face?
- What threats do the medical center's weaknesses expose it to?

- What is the impact of MyVA?
- How do employees view working at VA compared to two or three years ago? If there is a change, what is driving it?
- In your view, what is the most important factor affecting patient satisfaction with the care you provide?
- In your view, has there been a change in the perception of the quality of care provided by the medical center? If so, what might be driving this different perception?

Once the Commissioners completed their visits, they provided the data they gathered to Commission staff to be organized in a strengths-weaknesses-opportunities-threats (SWOT) analysis framework. A SWOT analysis is a simple but useful framework for analyzing the four factors as they are faced by an organization. It helps organizations develop strengths, minimize threats, and take the greatest advantage of available opportunities.⁸⁰²

Findings

VHA leadership and staff enthusiastically shared their time, insights, perspective, and data on organizational and operational processes with the Commissioners. The site visits provided insight and reinforced the findings of the *Independent Assessment Report*.

Confirming what the *Independent Assessment Report* stated, the Commissioners found VHA facilities' staff members exhibit a deep commitment to serving veterans, but that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.⁸⁰³ Based on Commissioners' observations of weaknesses, challenges, and threats related to daily operations, VAMC staff members appear to be searching for suitable solutions. Anecdotal responses provided to the Commissioners illuminated the following systemic problem areas at the VAMCs:

- Care authorities: health care capabilities (i.e., purchased care)
- Staffing: productivity (i.e., human resources), health care capabilities, access standards, clinical workflow
- Leadership: staffing, productivity (i.e., human resources)
- Facilities: health care authorities (i.e., patient-centered community care)

Data from Commissioners' observation notes were organized into a SWOT analysis chart based on the common themes of the Commissioners' facility site visits. The purpose of this exercise was to gather information to inform the Commission's recommendations and to confirm or

⁸⁰² "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.

⁸⁰³ "Veterans Integrated Service Networks (VISN)," Department of Veterans Affairs, VHA, accessed March 14, 2016 <http://www.va.gov/directory/guide/division.asp?dnum=1>.

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dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below.

Table F-7. SWOT Analysis of Commissioner Site Visit Observations

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> ▪ VA medical center workforce customer service and dedication ▪ Research and national databases ▪ Veterans service – connected services and programs ▪ Partnerships with medical schools and training programs 	<ul style="list-style-type: none"> ▪ Inefficient/ineffective HR policies ▪ High levels of staffing vacancies ▪ Lack of clinical space; inefficient configurations of clinical space ▪ Poor access to VA care for rural veterans ▪ Lack of an effective financial system to provide real-time payment process to veterans Choice and Purchased Care Programs ▪ Lack of effective VHA leadership workforce ▪ Lack of capacity/access to appointments in VHA ▪ Insufficient federal government health care appropriation rules 	<ul style="list-style-type: none"> ▪ Modernization of VA IT ▪ Customer service training/standards ▪ Strategic focus on VHA core mission ▪ Local funding flexibility from Congress ▪ New vision and mission for VHA health care ▪ Process/systems reengineering ▪ Recruitment of outside leader candidates and retention of high-performing VHA leaders 	<ul style="list-style-type: none"> ▪ Misalignment between Congress's health care operational plans for veterans and VHA strategic health care plans ▪ Competing stakeholders health care interests ▪ Office of Personnel Management outdated standards/policies ▪ Insufficient VHA leadership development ▪ Insufficient IT funding ▪ The physician shortages around the nation has severely impacted the care of patients

Conclusions

Fundamental transformation of VHA is needed to ensure optimal delivery of veteran-centered, high-quality care. Essential to laying the path to excellence and strategic planning is a comprehensive understanding of the current state as well as the opportunities and threats facing the system. A robust connection between leaders in VHA Central Office and leaders in the field is critical to meet the needs of the veteran population served.

As part of the strategic planning process, VA/VHA leadership should make recurring site visits to VHA facilities, including VAMCs, VISN headquarters, and CBOCs to obtain current insight of the following critical areas: health care trends, health care operations, facility management and renovation/replacement, business processes and contracting, and other trends or issues affecting VAMCs. VA/VHA leaders should use performance management tools and activities to ensure the strategic goals are being met in an effective and efficient manner. It is a constant challenge to continuously and reliably measure the pulse of the organization. Site visits promote a healthy culture of sharing and building an understanding of organizational mission.

APPENDIX G: VETERAN FEEDBACK

In addition to the more than 4,000-page *Independent Assessment Report*, the Commission examined dozens of other reports, studies, and presentations as cited in the hundreds of footnotes dispersed throughout this Final Report. Collectively, these many sources provide a wealth of information on the challenges VHA confronts in realizing a vision for veterans' healthcare that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

A key source the Commission considered was the views of veterans themselves. Given the Commission's brief tenure, it was not possible to conduct a survey representative of the views of millions of veterans receiving health care from VHA. Instead, the Commission encouraged veterans to offer feedback on their health care experiences and the work of the Commission through its website. Many veterans service organizations (VSOs) also provided views representing their members in open sessions with the Commission and in formal letters and position statements directly to the Commission.

The feedback offered by veterans through the Commission's web site covered a range of health care topics, such as whether and to what extent care should be privatized, how much choice veterans should have in deciding on their care, and their assessment of the quality of care received. Not surprisingly, veterans (including a few who were also VA employees) are quite passionate about their views on health care. For the most part, veterans' feedback from the web site expressed opposition to efforts to *privatize* VHA, although a few did want more access to non-VA providers. The *Choice Program* was frequently criticized for long delays in appointments, convoluted or misapplied eligibility criteria, and issues with how providers should be reimbursed for treatment and how much the veteran should pay. When the quality of care was noted, on balance veterans praised the care received from VHA, with a few disappointed, especially when care was outsourced to non-VA providers. Because the feedback was unstructured, veterans could offer any observations they found pertinent.

The Disabled American Veterans (DAV) shared with the Commission a compendium of more than 4,000 verbatim comments on veterans' health care experiences gathered from their members during April 2016. The DAV reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."⁸⁰⁴ The Commission staff reviewed the comments from DAV, with findings consistent to DAV's.

⁸⁰⁴ Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

VA Efforts to Gather Input on Veterans Views on Health Care

Like most institutions that provide products and services to customers, VA/VHA solicits input from veterans on their health care needs and their views on specific services VA/VHA provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, VA, like most agencies, encourages veterans and others to submit comments on a particular aspect of VA services and benefits.⁸⁰⁵

The following sections describe the more typical methods employed by VA/VHA to gather input from veterans.

VHA Survey of Veterans' Health and Use of VHA

Conducted by the assistant deputy undersecretary for policy and planning, the survey of veteran enrollees' health and use of health care (Survey of Enrollees) is an annual survey of more than 40,000 veterans who are enrolled in VA's health care system. The Survey of Enrollees was initially designed to give VHA the information it needed to predict the demand for services in the future. The data are used to develop health care budgets and to assist VA with its annual enrollment decisions. Over the years, the data have also been used to analyze policy decisions, provide insights into specific populations and their perspectives, and inform management decisions affecting delivery of care. In addition to collecting basic demographic information, the survey explores insurance coverage, use of health care inside and outside of VA, pharmaceutical use, attitudes and perceptions about VHA services, perceived health status, and trends in smoking among veterans enrolled in the VHA system.⁸⁰⁶

Survey of Healthcare Experiences of Patients⁸⁰⁷

The Survey of Healthcare Experiences of Patients (SHEP) program was initiated in 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. In an effort to standardize its survey instruments with other health care providers, SHEP now employs the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology for VHA's primary care and inpatient medical and surgical services. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys,

⁸⁰⁵ "Quality of Care Feedback Form," Department of Veterans Affairs, accessed June 20, 2016, <http://www.va.gov/QUALITYOFCARE/apps/contact.asp>. As an example, the VA web site provides a Quality of Care feedback page for veterans and others to enter comments on the care a veteran received.

⁸⁰⁶ Westat, 2015 Survey of Veteran Enrollees' Health and Use of Health Care, accessed June 6, 2016, http://www.va.gov/healthpolicyplanning/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁸⁰⁷ For more details on SHEP and VHA's recent initiatives to expand the scope of the program, see "Health Services Research & Development, Commentary: Listening to Veterans about Access to Care," Steven M. Wright, VHA Office of Analytics and Business Intelligence, U.S. Department of Veterans Affairs, accessed June 20, 2016, <http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1>.

the access questions were limited and did not evaluate the full scope of services used by veterans.

VHA intends to expand the SHEP program with additional surveys in 2016 and beyond. These surveys will focus on satisfaction with various specialty care services and experience with community care available through the Veterans Access, Choice, and Accountability Act of 2014. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

VHA also established a Veteran Insights Panel, comprising more than 3,200 veterans that are representative of users of VA health care.⁸⁰⁸ VHA interacts with the panel through email notification and a special access website (mobile device enabled). This approach provides VHA an opportunity to engage panel members in direct discussions, including real time feedback via live chat, about important themes and issues, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our veterans.

Voices of Veterans: On-going Research

Initiated in the spring of 2014, the VA Center for Innovation (VACI) sponsors an on-going effort to employ human-centered design (HCD)⁸⁰⁹ concepts in a pilot to explore veterans' experience with VA through the eyes of 40 veterans across a range of demographics and locations.⁸¹⁰ The pilot had two goals:

- To test the usefulness and application of an HCD methodology within the context of VA.
- To better understand veterans' experiences interacting with VA, identify pain points in the present day service delivery model, and explore opportunities to transform these interactions into a more veteran-centered experience.

Developing Veteran Personas

As a part of this pilot, VACI set out to identify high-level trends in ways veterans seek out assistance, use technology, take advantage of services, and react to challenging interactions. Based on these patterns, VACI created a set of four profiles, or personas, that represent the

⁸⁰⁸ Ibid.

⁸⁰⁹ Human-centered design (HCD) is a discipline in which the needs, behaviors and experiences of an organization's customers (or users) drive product, service, or technology design processes. It is a practice used heavily across the private sector to build a strong understanding of users, generate ideas for new products and services, test concepts with real people, and ultimately deliver easy-to-use products and positive customer experiences. HCD is a multi-disciplinary methodology which draws from the practices of ethnography, cognitive psychology, interaction and user experience design, service design, and design thinking. It is closely tied to "user-centered design," which applies parallel processes to technology projects, and "service design" which address the service specific experiences.

⁸¹⁰ U.S. Department of Veterans Affairs, Center for Innovation, *Toward a Veteran-Centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report, July 2014*, accessed June 20, 2016, http://www.innovation.va.gov/docs/Toward_A_Veteran_Centered_VA_JULY2014.pdf.

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kinds of users within the set of 40 veterans engaged in the pilot (see Table G-1). Each persona is an archetype based on commonalities observed among veterans who exhibited similar behaviors and approaches to accessing VA services. They are not categorized by positive or negative experiences, but by shared expectations and needs. These personas were designed to help VHA begin to understand that it is serving users who are seeking not just different services, but also varied degrees of contact, support, information, and so forth. For this exercise, VACI assessed veterans' modes of communication, channels, frequency, stated and observed needs, reactions to service experiences, military service, and analyzed observed behavior and service experiences.

*Table G-1. Veteran Profiles Developed by the VA Center for Innovation*⁸¹¹

THE LIFER	THE TRANSACTIONAL
<p>Frequently use VA services and plans to continue doing so. Look to VA to play a supporting, community-building role in life. Grateful for VA benefits, but get frustrated when problems arise which break up the continuity of care—like when doctors change too frequently and when they cannot get transportation to VA facilities. Generally, try to speak highly of VA and wants to contribute to making it work better for fellow veterans.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA cares and takes the time to understand veteran's needs and story ▪ That cost of VA services won't rise ▪ That veteran can reach someone at VA anytime <p>Needs</p> <ul style="list-style-type: none"> ▪ Does not want to tell story over and over, especially after using VA for so long ▪ Wants to know what is going on with services and especially benefits ▪ Likes patient, nurturing health care 	<p>Joined the military largely based on the promise of the opportunities it would provide in life. Plan to use VA services to "get life on track" post-service. Tend to be in the younger generation of veterans (OEF, OIF, OND). Often engaged in the veteran community, see other veterans as allies, and advocates in helping folks understand and use their benefits. Will share frustrations if feels like VA is not helping as promised.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA will deliver on its promises and help veteran access the benefits earned ▪ That VA has benefits available to veterans families ▪ That it will be a headache, and veterans will have to figure it out on their own with the help of network <p>Needs</p> <ul style="list-style-type: none"> ▪ Accurate expectations ▪ Financial support at times, especially for family ▪ To feel a part of a community

⁸¹¹ Ibid.

THE JUST-IN-CASE	THE INFREQUENT
<p>Proud of service, but does not need VA and plans on using it only as a backup. Mature and organized by nature, has all papers in order with VA and have a good idea of services for which they are eligible. Grateful for the benefits available, but see working with VA as a tradeoff for time and will likely only lean on VA as a backup plan.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That will likely never need VA benefits ▪ That VA will be there if needed ▪ That there are benefits available to family ▪ That private benefits are of higher quality and greater ease <p>Needs</p> <ul style="list-style-type: none"> ▪ Peace of mind ▪ To be assured that all documents are in order ▪ To easily get in touch with one person about one question 	<p>Does not think very much about VA. Have used VA benefits in lifetime, yet often years will go by between those interactions. This might be because these veterans live in places where it is difficult to access VA services, because veterans are financially comfortable, or because it seems like too much hassle. Tend to prefer quick interaction—a short phone call or a few clicks on a website.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA is slow—like any bureaucracy ▪ That VA is for “other, injured veterans who need it more” ▪ That someone will tell veterans when and if they are eligible for something <p>Needs</p> <ul style="list-style-type: none"> ▪ To be able to quickly navigate processes ▪ To be reminded every few years of how VA might be able to help

Vantage Point: VA’s Official Blog

In addition to surveys, focus groups, and town-hall sessions, VA instituted a blog on its website and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Like most blogs, the content offered is vetted by the VA. Since 2010, Vantage Point includes hundreds of contributors with articles on various health care topics.⁸¹²

Veterans’ Views Gathered by VSOs

Like VHA, the VSOs solicit input from their membership and other stakeholders on a variety of topics and issues relevant to veterans. Occasionally surveys and polls are undertaken, but most VSO efforts to gather input take place at the grassroots level during town halls, chapter meetings and other gatherings. While these venues often suffer from self-selection bias and non- or under-represented participant samples, these are nevertheless an important source of timely information on topics of interest and concern to veterans. What follows is a selection of VSO efforts to gather input on issues important to veterans.

⁸¹² “Vantage Point: Official Blog of the U.S. Department of Veterans Affairs,” Department of Veterans Affairs, accessed June 20, 2016, <http://www.blogs.va.gov/VAntage/>.

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The DAV Veterans Pulse Survey (2015)

In mid-2015 the DAV surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.⁸¹³ The survey includes questions on various aspects of veterans' healthcare. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the United States. Oversampling occurred in certain subgroups, such as female veterans and veterans age 18-40 to allow for more precision in the response estimates for these subgroups.

Veterans of Foreign Wars Our Care Veterans Survey (2015)

In the fall of 2015, the Veterans of Foreign Wars of the U.S. (VFW) published a report on its veterans 2015 Health Care Options, Preferences and Expectations Survey.⁸¹⁴ In response to the intensified debate over reform of veterans' healthcare, the VFW launched a survey in the summer of 2015 designed to evaluate veterans' options, expectations, and preferences when seeking health care. The survey did not just focus on VA services, but sought to paint a picture of how the veterans' community at large interacts within the American health care infrastructure, and the choices they make in today's health care marketplace. According to the VFW report, 1,847 veterans responded to the survey, with 92 percent eligible for care and 83 percent of those eligible reporting that they utilize VA health care.⁸¹⁵ Respondents' average age was 65, with about two-thirds Vietnam War veterans.

VFW Survey of Women Veterans (2016)

In an effort to identify barriers women veterans face when accessing their earned veterans' benefits and services, the VFW has commissioned a survey of women veterans that will guide the VFW's policy priority goals for women veterans.⁸¹⁶ Though the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

⁸¹³ Disabled American Veterans (DAV), *The DAV Veterans Pulse Survey: A landmark study of the attitudes and perceptions of America's veterans*, accessed June 20, 2016, <https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf>. The survey was conducted on behalf of DAV by GfK Knowledge Networks, Inc. using their KnowledgePanel® survey participants in November 2015.

⁸¹⁴ Veterans of Foreign Wars, *Our Care: A Report on Veterans' Options, Preferences and Expectations in Health Care*, September 22, 2015, accessed June 20, 2016, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf.

⁸¹⁵ Ibid., 4.

⁸¹⁶ "VFW Survey of Women Veterans: Help Hold the VA Accountable," Veterans of Foreign Wars, December 22, 2015, accessed June 20, 2016, <http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/>.

The American Legion Survey of Patient Health Care Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's posttraumatic stress disorder/traumatic brain injury (PTSD/TBI) programs, including alternative and complementary treatments.⁸¹⁷

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI and/or PTSD; availability of appointments; time and distance to care facilities; treatment type (therapy, medication and complementary and alternative medicine); reported symptoms; efficacy of treatment; and side effects.

The American Legion Women Veterans Survey Report (2011)

This survey of 3,012 women veterans, and the resulting report, was prepared by ProSidian Consulting, LLC on behalf of The American Legion. The survey assessed the perceptions of and satisfaction with women veterans' health care and other benefits delivered to women veterans through the VA system. Additionally, the survey sought to determine the factors driving women veterans' decision to use the VA system as opposed to other private or public health care systems.⁸¹⁸

Iraq and Afghanistan Veterans of America Member Survey (2015)

During the first half of 2015, 1,501 Iraq and Afghanistan Veterans of America members completed a wide-ranging on-line survey covering such issues as employment, education, GI Bill usage, health (including mental health), VA utilization, VA benefits, reintegration and more. The survey was composed of approximately 300 questions, with respondents answering only questions relevant to their experiences. Health care topics included percent enrollment in and reliance on VA care; health insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA *Choice Program* was also covered separately.⁸¹⁹

The 2015 Wounded Warrior Project® Alumni Survey

This web-enabled, opt-in survey of 23,200 Wounded Warrior Project (WWP) members measures a series of outcome domains within the following general topics about WWP Alumni: background information (military experiences and demographic data), physical and mental well-being, and economic empowerment.⁸²⁰ This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-

⁸¹⁷ "Legion survey to measure effectiveness of PTSD/TBI treatment," The American Legion, July 29, 2015, accessed June 20, 2016, <http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment>.

⁸¹⁸ ProSidian Consulting, LLC, *The American Legion Women Veterans Survey Report*, March 9, 2011, accessed June 20, 2016, http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf.

⁸¹⁹ "Media Advisory: IAVA to Release Groundbreaking Veterans Survey," Iraq and Afghanistan Veterans of America (IAVA), May 23, 2016, accessed June 20, 2016, <http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/>.

⁸²⁰ Westat, *2015 Wounded Warrior Project Survey, Report of Findings*, August 14, 2015, accessed June 20, 2016, https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf.

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weights the reported results, to include adjustments for potential non-response bias, to be representative of the WWP membership base (approximately 59,000).

Right to Care: Voices of Swords to Plowshares' Veteran Community (2015)

The Swords to Plowshares, Institute for Veteran Policy interviewed in-person or by phone 22 veterans.⁸²¹ Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual “conversations” with a preselected group of veterans. The veterans were chosen to represent a cross-section of combat eras and VHA usage levels. The topics covered included: navigating VA care, reliance on VA and non-VA care, comprehensiveness of care, and rating quality of care. The study includes extensive verbatim comments from veterans on these topics.

Comments from Veterans About Their Experiences as Users of VHA (DAV, 2016)

During April 2016, DAV reached out to veterans around the United States and asked them to share their experiences with the VA health care system. As a result, DAV received (as of April 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from VHA.⁸²² The Commission’s review of the material showed that a majority of the veterans’ comments were positive in nature. DAV’s own analysis concluded that 82 percent of the comments could be categorized as “overall positive experiences.”

Other Surveys on Veterans Issues

In addition to efforts by VA and VSOs to gather feedback from veterans on their health care, other organizations have also addressed veterans’ health care issues.

Concerned Veterans for America Survey of Veterans' Healthcare (November, 2014)

The Concerned Veterans for America commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014.⁸²³ This survey used a random, demographically representative sample of veterans. Four survey items addressed health care, including: knowledge of any problems at VA; need for reform of veterans’ healthcare; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

⁸²¹ Megan Zottarelli, *RIGHT to CARE: Voices of Swords to Plowshares' Veteran Community*, Swords to Plowshares, Institute for Veterans Policy, April 2016.

⁸²² Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

⁸²³ Concerned Veterans for America, *Fixing Veterans Health Care*, A Bipartisan Policy Taskforce, accessed June 20, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

Vet Voice Foundation Survey of Veterans (October, 2015)

Chesapeake Beach Consulting and Lake Research Partners conducted 800 phone (landline and cell) interviews of veterans during October 2015. The results were population weighted by demographics. Topics included rating the job VA hospitals are doing in their area and the extent they favor/oppose privatizing some of VA's health care.

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APPENDIX H: ADDITIONAL RESOURCES

The VHA health care system is immense and complex. This report provides background for the areas for which the Commission has made recommendations, yet this information is but a glimpse at the intricacies of veterans' health care. The resources below may serve as a starting point for those who would like to develop a deeper understanding of the topic than the Commission could address in this report.

Independent Assessment Report

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow – Scheduling)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow – Clinical)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

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Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

Veteran Health Competency Resources

American Nurses Foundation

The American Nurses Foundation, the philanthropic arm of the American Nurses Association, is launching an innovative web-based PTSD Toolkit for registered nurses. The toolkit provides easy to access information and simulation based on gaming techniques on how to identify, assess and refer veterans suffering from PTSD. www.nurseptsdtoolkit.org

American Osteopathic Association

The American Osteopathic Association (AOA) represents osteopathic physicians, many of whom are in primary care practice, and essentially all of whom treat America's veterans and their families. The AOA is raising awareness in the osteopathic community about the importance of having a comprehensive understanding of the unique physical and mental health care needs of our service members, veterans, and their families. The AOA is committed to ensuring that medical students, physicians, and other health care providers understand that an individual's physical and/or mental health condition may be linked to his or her military experience.

www.osteopathic.org/inside-aoa/public-policy/Pages/federal-initiatives.aspx

Center for Deployment Psychology

The Center for Deployment Psychology of the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology offer a wide variety of on-line courses and other resources to help uniformed clinical providers, VHA providers, and community clinicians provide care consistent with the needs and experience of military service members, veterans and their families.

<http://deploymentpsych.org/online-courses>

<http://deploymentpsych.org/military-culture-course-modules>

Rural Clergy Training Program

The Rural Clergy Training Program, an initiative of the VHA National Chaplain Center and the Office of Rural Health, offers training and information to clergy providing pastoral services to veterans and their families.

http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December_2015.pdf

Swords to Plowshares Combat to Community Training

Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans. Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by its Institute for Veteran Policy team with the purpose of educating the community to address the reintegration challenges veterans face and the unique skill sets they acquire in service. The training was developed for law enforcement, first responder, mental health, and service professionals to teach:

- Commonly shared attitudes, values, goals, and practice that often characterize service in the military
- Recruitment and retention strategies for veteran employment
- How deployment, combat experience, service related injuries, and disability can impact veterans
- How veteran or military family status can inform interactions and services
- Potential resources to refer veterans and families to for supportive services

The training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase understanding and improve interactions with veterans.

<https://www.swords-to-plowshares.org/combat-to-community>

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VA Military Culture Training Courses on TMS

The resources below are available to VA employees and contractors. Versions of these courses should be made available to community providers through an alternative to TMS that allows outside providers to access the training.

- **Military Culture Training for Health Care Professionals – Organization and Roles (VA 19332)**

The first module of this online course provides an overview of the differences between the explicit and implicit features of military culture and describes the characteristics of implicit military culture. The next module identifies four sources of information about implicit military culture and describes six defining characteristics of warrior ethos. The learner is provided information about the influence of military guiding ideals and values on the lives of service members and veterans. The final module offers an overview regarding the connotations of implicit military culture on the health care professional.

- **Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)**

This online course, sponsored by the Department of Veterans Affairs and Department of Defense, helps health care professionals understand the role that military culture plays in the lives of those they serve. The course is comprised of four modules: 1) Self-Assessment and Introduction to Military Ethos, 2) Military Organization and Roles, 3) Stressors and Their Impact, and 4) Treatment Resources and Tools.

- **Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)**

This online course offers the learner an explanation of how stress can be either helpful or harmful depending on the nature of the provoking stressor and the availability of resources. The four phases of modern operational deployment cycles is presented in great detail in module 3. The next two modules describe the characteristic operational stressors and the spectrum of operational stress states and outcomes experienced by service members and their families during each deployment cycle phase.

- **Military Culture Training for Health Care Professionals: Treatment Resources, Prevention & Treatment (VA 19335)**

This online course in the military culture curriculum outlines the military culture impact on patient care and the health care professional's role and explains the range of DoD and VA psychological health services. The course also provides information on interpreting military culture knowledge into patient assessment and treatment. Finally, the learner is exposed to the military culture implications of VA/DoD clinical practice guidelines relevant to the care of service members and veterans and the strategies for identifying current military culture relevant patient and health care professional resources.

- **Military Cultural Awareness (NFED 1341520)**

This military cultural awareness online course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which veterans have served, and why this information

is important in helping VA employees better serve the needs of veterans and their families. After taking this course, participants will understand the perspective of the veterans they serve by having a greater awareness of the military experience, and the customs and courtesies that are common in the military environment.

- **PTSD 101: Understanding Military Culture When Treating PTSD (VA 9494)**
This online web-based course is part of the PTSD 101 education series which is presented by subject-matter experts to increase provider knowledge related to the assessment and treatment issues of PTSD. Each course specifically addresses trauma events, treatments, or special population issues, not normally addressed in general therapy protocols. This course is specifically designed to familiarize clinicians with military culture, terminology, demographics, and stressors. It also provides an overview of programs offered by DoD for managing combat or operational stress, as well as implications for assessment and treatment.
- **Why Military Culture Matters (Mobile Accessible) (VA 16353)**
This independent online study activity is designed to help the learner better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using a VA networked mobile device.

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APPENDIX I: ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT. —

(1) ASSESSMENT. — Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

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(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(I) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third- party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS. —

(A) SCHEDULING ASSESSMENT. — In carrying out the assessment required by paragraph (1)I, the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

COMMISSION ON CARE FINAL REPORT

(1) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department –

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT. – In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(1) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING. – The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED. – A private entity described in this subsection is a private entity that –

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR. —

(1) IN GENERAL. — If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES. — The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT. —

(1) IN GENERAL. — Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION. — Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED. — In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION. —

(1) IN GENERAL. — There is established a commission, to be known as the “Commission on Care” (in this section referred to as the “Commission”), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP. —

(A) VOTING MEMBERS. — The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

COMMISSION ON CARE FINAL REPORT

(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS. — Of the members appointed under subparagraph (A) —

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

I DATE. — The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT. —

(A) IN GENERAL. — Members shall be appointed for the life of the Commission.

(B) VACANCIES. — Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING. — Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS. — The Commission shall meet at the call of the Chairperson.

(6) QUORUM. — A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON. — The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION. —

(1) EVALUATION AND ASSESSMENT. — The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED. — In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS. — The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION. —

(1) HEARINGS. — The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES. — The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS. —

(1) COMPENSATION OF MEMBERS. —

(A) IN GENERAL. — Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily

COMMISSION ON CARE FINAL REPORT

equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES. — All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES. — The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF. —

(A) IN GENERAL. — The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION. — The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES. — Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES. — The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION. — The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING. — The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION. —

(1) ACTION ON RECOMMENDATIONS. — The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to

implement each recommendation set forth in a report submitted under subsection (b)(3) that the President —

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS. — Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

H.R. 4437: Extension of Deadline for Submittal of Final Report by Commission on Care

[114th Congress Public Law 131]

[[Page 130 STAT. 292]]

Public Law 114-131

114th Congress

An Act

To extend the deadline for the submittal of the final report required by the Commission on Care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 38 USC 1701; EXTENSION OF DEADLINE FOR SUBMITTAL OF FINAL REPORT BY COMMISSION ON CARE.

COMMISSION ON CARE FINAL REPORT

Section 202(b)(3)(B) of the Veterans Access, Choice, and Accountability Act of 2014, 128 Stat. 1775 (Public Law 113-146; 128 Stat. 1773) is amended by striking “Not later than 180 days after the date of the initial meeting of the Commission” and inserting “Not later than June 30, 2016”.

Approved February 29, 2016.

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
COMMISSION ON CARE

1. OFFICIAL DESIGNATION: Commission on Care
2. AUTHORITY: The Commission on Care established as required by section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113-146, and operates under the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.
3. OBJECTIVES AND SCOPE OF ACTIVITIES: The Commission on Care (the "Commission") is established to examine the access of Veterans to health care from the Department of Veterans Affairs (VA) and strategically examine how best to organize the Veterans Health Administration (VHA), locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of VACAA, August 7, 2014.
4. DUTIES OF THE COMMISSION:
 - A. Evaluation and Assessment: In accordance with section 202(b)(1), the Commission shall undertake a comprehensive evaluation and assessment of access to health care at VA.
 - B. Matters Evaluated and Assessed: In undertaking the comprehensive evaluation and assessment required by section 202(b)(1) of VACAA and paragraph (4)(A) above, the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201 of VACAA, including any findings, data, or recommendations included in such assessment.
 - C. Reports: In accordance with section 202(b)(3) of VACAA, submit an interim report not later than 90 days after the initial meeting of the Commission to the President, through the Secretary of Veterans Affairs, and a final report not later than 180 days after the initial meeting of the Commission. The reports shall include (i) the findings of the Commission with respect to the evaluation and assessment required by section 202(b)(1); and (ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through VHA.
5. OFFICIAL TO WHOM THE COMMISSION REPORTS: The Commission reports to the President, through the Secretary of Veterans Affairs.

VA is responsible for ensuring the reporting requirements of Section 6(b) of the FACA are fulfilled.

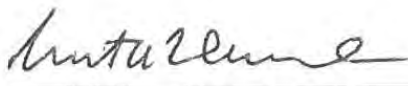
COMMISSION ON CARE FINAL REPORT

6. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMISSION: VHA is responsible for providing support to the Commission.
7. ESTIMATED ANNUAL OPERATING COSTS AND STAFF-YEARS: Annual operating cost for the Commission is estimated at \$3,600,000 per year, including compensation of members and staff, in accordance with section 202(d) of VACAA. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Commission. Approximately 15 FTE are anticipated.
8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO) or an Alternate DFO, full-time or permanent part-time VA employees, will be present at all meetings, including subcommittee meetings. The DFO will work with the Commission Chair to schedule the meetings and develop meeting agendas. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.
9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet at the call of the Chair for the duration of the Commission. The Commission may hold such hearings, sit and act at such times and places, and take such testimony, and receive such evidence as the Commission considers advisable to carry out its duties under section 202 of VACAA. A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.
10. DURATION: The Commission is subject to the termination date as specified below in section 11.
11. TERMINATION: The Commission shall terminate 30 days after the date on which the Commission submits the final report required by section 202(b)(3)(B) of VACAA.
12. MEMBERSHIP: The Commission shall be composed of 15 voting members who are appointed as Special Government Employees and described in paragraph (A) below for the life of the Commission and have the qualifications described in paragraph (B) below:
 - A. APPOINTMENT AUTHORITY:
 - i. Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a Veteran.
 - ii. Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a Veteran.

- iii. Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a Veteran.
 - iv. Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a Veteran.
 - v. Three members appointed by the President, at least two of whom shall be Veterans.
- B. QUALIFICATIONS: Of the members appointed under 12(A) –
- i. At least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of Veterans under 38 U.S.C. 5902;
 - ii. At least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;
 - iii. At least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined by in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B));
 - iv. At least one member shall be familiar with VHA but shall not be currently employed by VHA; and
 - v. At least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.
- C. CHAIRPERSON AND VICE CHAIRPERSON: The President shall designate a member of the Commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.
- D. VACANCIES: If a vacancy occurs, it shall be filled in the same manner as the original appointment.
13. SUBCOMMITTEES: The Commission is authorized to establish subcommittees, with DFO approval, to perform specific projects or assignments as necessary and consistent with its mission. The Commission Chair shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership, and estimated duration. Subcommittees will report back to the Commission.
14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 26 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act 5, U.S.C. 552.

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15. DATE CHARTER IS FILED:

Approved:  Date 7/14/15
Robert A. McDonald
Secretary of Veterans Affairs



APPENDIX J: COMPOSITION OF THE COMMISSION

Nancy M. Schlichting, Chairperson

Appointed by President Barack Obama

Nancy M. Schlichting is Chief Executive Officer of Henry Ford Health System (HFHS), a nationally recognized \$5 billion health care organization with 27,000 employees and recipient of the 2011 Malcolm Baldrige National Quality Award, 2011 John M. Eisenberg Patient Safety Quality Award, and 2004 Foster G. McGaw Award. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service and diversity initiatives.

Schlichting joined HFHS in 1998 as its Senior Vice President and Chief Administrative Officer, served as Executive Vice President and Chief Operating Officer, President and CEO of Henry Ford Hospital and was named President and CEO of the System in 2003. Her career in health care administration spans over 35 years of experience in senior level executive positions.

Schlichting serves on several national and community boards including The Kresge Foundation, Walgreens Boots Alliance, the Federal Reserve Bank of Chicago – Detroit Branch, the Detroit Regional Chamber, the Detroit Economic Club, and the Downtown Detroit Partnership. Nancy is also a Fellow of the American College of Healthcare Executives.

In 2015, Schlichting was honored as one of the 100 Most Influential People in Healthcare by Modern Healthcare magazine, the eighth time she received this recognition. She was also named to the Top 25 Women in Healthcare by Modern Healthcare, the fourth time she received this recognition and the only Michigander named to the list. Her other awards include: NCHL Gail L. Warden Leadership Excellence award, ACHE Senior-Level Healthcare Executive Regent's Award, AHA/HRET 2014 TRUST Award, Becker's Hospital Review "40 of the Smartest People in Healthcare-2014," Crain's Detroit Business "2012 Newsmaker of the Year," HealthLeaders Media "20 People Who Make Healthcare Better-2012," and most recently was named one of "Crain's 100 Most Influential Women in Michigan."

Author of the acclaimed book, *Unconventional Leadership*, Schlichting is a highly regarded expert and accomplished speaker on strategic leadership, quality, patient/family-centered care, and diversity.

Schlichting received her A.B. in Public Policy Studies, Magna Cum Laude from Duke University and her M.B.A. from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College, Eastern Michigan University and Central Michigan University.

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Delos M. (Toby) Cosgrove, MD, Vice Chairperson*Appointed by Speaker of the House John Boehner*

Toby Cosgrove, CEO of Cleveland Clinic, presides over a \$6.2 billion health care system comprising Cleveland Clinic, eight community hospitals, 16 family health and ambulatory surgery centers, Cleveland Clinic Florida, the Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Toronto, and Cleveland Clinic Abu Dhabi. His leadership has emphasized patient care and patient experience, including the reorganization of clinical services into patient-centered, organ- and disease-based institutes. He launched major wellness initiatives for patients, employees, and communities. Under his leadership, Cleveland Clinic has consistently been named among America's top four hospitals by U.S. News & World Report and is one of only two hospitals named among America's 99 Most Ethical Companies by the Ethisphere Institute.

Cosgrove was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam, as the chief of U.S. Air Force casualty staging flight. He received the Bronze Star and the Republic of Vietnam Commendation Medal.

He has published nearly 450 journal articles, book chapters, one book, and 17 training and continuing medical education films. He performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments.

Cosgrove received his medical degree from the University of Virginia School of Medicine in Charlottesville, VA, and completed his clinical training at Massachusetts General Hospital, Boston Children's Hospital, and Brook General Hospital in London. He received a BA in biology from Williams College in Williamstown, MA.

Michael A. Blecker*Appointed by House Minority Leader Nancy Pelosi*

Michael Blecker has been associated with Swords to Plowshares since 1976 and has served as Executive Director since 1982. The agency was started in 1974 by returning Vietnam veterans and VISTA volunteers assigned to the VA regional office in San Francisco.

In the 1980s, when homelessness exploded, Swords to Plowshares started a transitional housing program with funding support from VA and the city and county of San Francisco. Swords to Plowshares continues to provide housing, employment, case management, and benefits advocacy for veterans from offices in San Francisco and Oakland. In 2005, the Iraq Vet Project (IVP) was established to help veterans of those wars and to shape policies affecting them. Recognizing Swords to Plowshares' long and effective history of challenging and shaping public policy with regard to veterans, in 2011, the IVP became known as the Institute for Veterans Policy.

Under Blecker's leadership, Swords to Plowshares' annual budget has grown from \$75,000 to nearly \$16 million. He has a nationwide reputation for dedicated service and as an authority on

veterans' services and veterans' rights. He served on the Advisory Committee on Homeless Veterans (2002-2007), which advises the Secretary of Veterans Affairs. He is cofounder of both the National Coalition for Homeless Veterans and the California Association of Veterans' Service Agencies. He has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, the National Agent Orange Settlement Advisory Board, The Agent Orange Information Center, and the Veterans Speakers Alliance.

Blecker served in the U.S. Army as a combat infantryman in Vietnam in 1968-69 with the 101st Airborne Division, achieving the rank of E-5. He received an AB degree in criminology from University of California, Berkeley and a JD degree from New College of California Law School.

David P. Blom

Appointed by Speaker of the House John Boehner

David Blom has been instrumental in the development and growth of the OhioHealth system. He has served as president of OhioHealth's central Ohio hospitals – Grant Medical Center, Riverside Methodist Hospital, and Doctors Hospital – while also serving as executive vice president and chief operating officer of OhioHealth. He was named president and CEO of OhioHealth in March 2002. He has a track record of achievement with a solid understanding of complex issues facing health care delivery. He has expertise in leading strategic initiatives, managing and developing human capital, improving profitability, and improving quality of care and customer experience.

Blom maintains many professional and community affiliations, currently serving as a board member of the Voluntary Hospitals of America (VHA), a member and treasurer of Columbus' Downtown Development Corporation (CDDC), member of the Columbus Partnership, and member of the local World President's Organization (WPO). In 2001, he was named a Top 100 Business Leader by Smart Business and in 2012 CEO of the Year by Columbus CEO Magazine.

He received a BA from Ohio State University and an MA in health care administration from The George Washington University.

David W. Gorman

Appointed by President Barack Obama

David Gorman is a retired, combat-disabled veteran of the Vietnam War, who was appointed executive director of the Disabled American Veterans (DAV) National Service and Legislative Headquarters in Washington, DC in 1995. His responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House, and the U.S. Department of Veterans Affairs.

Gorman entered the U.S. Army in 1969 and served with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam

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where U.S. forces suffered extremely high casualties, Mr. Gorman was severely wounded. His wounds required amputation of both legs.

Discharged from the Army in 1970, he immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and DAV Chapter 39 in Greer, SC.

Gorman retired from his post executive director at the Washington Headquarters for Disabled American Veterans and now resides in Simpsonville, SC. Gorman attended Cape Cod Community College.

The Honorable Thomas E. Harvey, Esq.

Appointed by Senate Majority Leader Mitch McConnell

Thomas Harvey is a Vietnam combat veteran whose decorations include the Silver Star, the Purple Heart and 12 others for valor and service. In Vietnam, he spent a year as a company commander with the 173rd Airborne brigade and a year and a half as an advisor with the Vietnamese Airborne Division.

A lawyer by training, Harvey has spent much of his professional career working with veterans and issues of concern to them. He has served as Chief Counsel and Staff Director of the Senate Veterans Affairs Committee, Deputy Administrator of the Veterans Administration, and Assistant Secretary for Congressional Affairs of the Department of Veterans Affairs. Following 5 years with a major Wall Street law firm, Harvey came to Washington, DC, in 1977 as a White House fellow, serving as an assistant to ADM Stansfield Turner, then director of the Central Intelligence Agency. He has also served in the Department of Defense and as General Counsel and Congressional Liaison of the United States Information Agency. For 5 years, he was Senior Counselor of the Institute of International Education, which administers the Fulbright Program on behalf of the U.S. Department of State, as well as a number of other international educational exchange programs.

He currently serves on the boards of the Milbank Memorial Fund, the focus of which is public health policy, and of the Art Students League of New York, where he studies watercolor painting. He holds both BA and JD degrees from the University of Notre Dame and a LLM degree from the New York University School of Law.

Maj. Stewart M. Hickey, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Since 2011, Stewart Hickey has served as American Veterans (AMVETS) National Executive Director, operating the nation's fourth largest congressionally chartered veterans service organization and its subordinate organizations, and the daily advocacy of issues affecting veterans, national security, foreign affairs, and the economy.

Previously, Hickey was chief executive officer for the Hyndman (Pennsylvania) Area Health Center, a multisite community health center providing medical and dental services to several counties of Pennsylvania, West Virginia, and Maryland. His health care administration experience includes serving as chief human resources officer and chief operating officer of

Western Maryland Hospital Center in Hagerstown, Maryland, a 123-bed Joint Commission on Accreditation of Healthcare Organizations accredited, long-term care and sub-acute hospital with rehabilitation, occupational therapy, physical therapy, and respiratory care.

Hickey enlisted in the U.S. Marine Corps Reserve in February 1977, in Cumberland, MD, as an infantryman, and transferred to platoon leaders class in the summer of 1978. He served in Operation Desert Storm and Desert Shield and was awarded a Bronze Star Medal with Combat "V" for his achievements as commanding officer, Company D, Third Tank Battalion, Task Force RIPPER, 1st Marine Division, I Marine Expeditionary Force, Saudi Arabia from September 1990 to February 1991. His military education includes the Basic School, Armor Officer Basic, Amphibious Warfare School, Armor Officer Advanced Course, and Marine Corps Command and Staff College.

Hickey resides on his family farm in Cumberland Valley Township in McConnellsburg, PA. He and his wife, Ellen, have five children: Monroe, Ali, Charles, Andrew, and Bryce. Three of his sons, Andrew, Monroe, and Charles, followed their father's path and currently serve in the U.S. military.

Hickey received a BA in history from Penn State University and an MA in management from Webster University.

Rear Adm. Joyce M. Johnson, DO, US PHS (ret.)

Appointed by President Barack Obama

Joyce Johnson is a physician with senior public health leadership experience in civilian and military sectors.

Johnson served in the U.S. Public Health Service (Rear Admiral, Upper Half). Her last active-duty assignment was with the U.S. Coast Guard as Director, Health and Safety ("surgeon general"). She managed the Coast Guard's health care system, including 150 sickbays and clinics, and coordinated both medical and behavioral health care for the beneficiary population. She also had responsibility for the Coast Guard's safety and work-life programs. She held a Top Secret security clearance.

Other government assignments included senior scientific and management positions with the Food and Drug Administration (pharmaceutical safety and post-market surveillance) and the Substance Abuse and Mental Health Services Administration. She has held clinical positions at the National Institute of Mental Health and the Department of Veterans Affairs. At the Centers for Disease Control and Prevention, she was an Epidemiologic Intelligence Service (EIS) Officer and staff epidemiologist in the Center for Infectious Disease.

In the private sector, Johnson served as vice president, health sciences and chief medical officer for a large research organization, where she managed a portfolio of government contracts, including laboratory and social sciences research, and held a top secret security clearance.

Johnson is an osteopathic physician board certified in psychiatry and public health/preventive medicine. She is also a certified clinical pharmacologist and certified addiction specialist. In

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addition to her medical degree, she earned a master's degree in hospital and health administration. She has been conferred six honorary doctoral degrees. She is a Distinguished Life Fellow of the American Psychiatric Association.

Johnson has extensive international health experience on all seven continents. She has particular interests in global mental health, health systems development, infectious disease, and disaster relief. She has led five Flag Expeditions with the Explorers Club. For more than a decade she has been a consultant to the National Science Foundation on the health care system in Antarctica.

Johnson recently coauthored the book, *Lizard Bites and Street Riots, Travel Emergencies and Your Health, Safety and Security*, and writes a monthly medical column. She is a Clinical Professor and Adjunct Professor at Georgetown University. She has served on expert committees including the Committee on Substance Abuse in the Military, National Academy of Medicine. She is active in numerous professional associations including the American Psychiatric Association, serving on the Committee on Psychiatric Dimensions of Disasters; the American Osteopathic Association, serving on the Bureau of International Osteopathic Medicine; and the Explorers Club, serving on the Medical Committee.

The Honorable Ikram U. Khan, MD

Appointed by Senate Minority Leader Harry Reid

Ikram Khan currently, he is president and 50-percent partner of Quality Care Consultants, LLC, founded in March 1992. The company provides consultant services in health care strategy and policy development for employers and other health care organizations. The company assists clients in development and implementation of wellness and disease-management programs. The company also develops quality improvement initiatives and techniques and assists in development and implementation of programs for cost-effective utilization of medical resources. Major emphasis is on clinical outcomes and data monitoring analysis.

Khan is a member the United States Institute of Peace (USIP) Board of Directors; he was nominated by President George Bush, and confirmed by the U.S. Senate on June 5, 2008. He is also currently a member of the Nevada Homeland Security Commission, having been appointed by the Governor of Nevada.

He was nominated by President Clinton and confirmed by the U.S. Senate to serve as member of The Board of Regents Uniformed Services University of Health Sciences, an advisory board to U.S. Secretary of Defense (1999-2006).

Khan also served as Special Advisor on Healthcare to Former Nevada Governor Gibbons, was a member of the Nevada Academy of Health (appointed by Nevada Governor Gibbons), and is a past member of the Nevada Academy of Health Sciences (appointed by Nevada Governor Kenny Guinn). He is past member of Nevada Governor's Commission for Medical Education, Research and Training and was a member of the Nevada State Board of Medical Examiners for eight years. Dr. Khan received "Special Congressional Recognition" for invaluable community service in 1994 and a Congressional citation—"U.S. Senate - Honoring Dr. Ikram Khan"—on April 25, 1994.

Khan currently serves as member on the board of trustees at Sunrise Hospital Las Vegas-a 600 bed hospital. He has received recognition as “Most Influential Man in Southern Nevada” in 2000. He is also a recipient of a Las Vegas Chamber of Commerce community achievement award (October 1999), and a “Distinguished Community Service Award” from Anti-defamation League of B’nai B’rith (1994).

November 30, 1999 was declared “Dr. Ikram U. Khan Day” by the Governor of the State of Nevada, Mayor of Las Vegas, and the Board of Commissioners of Clark County.

During the course of his practice as General Surgeon, Khan has served in multiple leadership positions at various hospitals in Las Vegas.

Ikram Khan is president of quality Care Consultants LLC in Las Vegas Nevada. He received a doctor of medicine and surgery (MBBS) degree from University of Karachi, Pakistan.

Khan received a Doctor of Medicine and Surgery (MB, BS) in August 1972 from the University of Karachi, Pakistan. He completed post-graduate surgical residency in General Surgery in New York from 1974 through 1978, and practiced as a General Surgeon in Las Vegas through 2005.

Phillip J. Longman

Appointed by Senate Minority Leader Harry Reid

Phil Longman is a director at New America, a public policy institute. He is also a senior editor at the Washington Monthly and a lecturer at Johns Hopkins University, where he teaches a course in health care policy.

Longman has written extensively on issues related to health care delivery system reform, including in his book *Best Care Anywhere* (currently in its third edition). The book chronicles the quality transformation of the Veterans Health Administration during the 1990s and applies its lessons to the broader U.S. health care system.

Longman received a BA in philosophy from Oberlin College.

Col. Lucretia M. McClenney, USA (ret.)

Appointed by House Minority Leader Nancy Pelosi

Lucretia McClenney is a consultant with the Department of Defense Vietnam War Commemoration Office and Executive Coach with the Brookings Institute Executive Education Program. Previously she served as director of the Department of Veterans Affairs Center for Minority Veterans. As director, she served as the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. Prior to her appointment, she served as special assistant to the assistant secretary for policy, planning, and preparedness, Department of Veterans Affairs (VA). She led the department’s emergency exercise planning, training, and evaluation program, and served as liaison to other government agencies. She has served on numerous working groups to include the congressionally mandated National Commission on VA Nursing, Task Force on Employment of Women at VA, and as the Secretary

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of Veterans Affairs' representative on the American Red Cross Board of Governors and Disaster and Chapter Services Committee.

Serving 30 years in the Army, McClenney retired as a colonel in November 2001. She served in various medical treatment facilities and on staffs worldwide serving as director, population health integration team, TRICARE management activity; chief nurse, European regional medical command and deputy commander for nursing, Landstuhl Regional Medical Command; deputy commander for nursing, Moncrief Army Community Hospital, Fort Jackson, South Carolina; assistant deputy for human resources, Office Of The Assistant Secretary Of The Army for Manpower and Reserve Affairs, the Pentagon; chief ambulatory nursing, Walter Reed Army Medical Center; senior policy analyst, Office of the Secretary of Defense (Health Affairs), The Pentagon; and member of the President's National Health Care Reform Task Force.

McClenney's military and civilian awards/decorations include the Legion of Merit (two oak leaf clusters), Defense Meritorious Service Medal, Meritorious Service Medal (seven oak leaf clusters), Army Commendation Medal (two oak leaf clusters), Navy Commendation Medal, Army Achievement Medal, Army Good Conduct Medal, the Army Staff Identification Badge, Office of the Secretary of Defense Staff Identification Badge, the coveted "9A" designator, in recognition of numerous achievements at the pinnacle of nursing excellence, and The Outstanding Civilian Service Medal for her significant contribution to the mission of the United States Army and Department of Defense in assisting with the production of the book, *For Children of Valor – Arlington National Cemetery*. Her professional affiliations include the Association of Military Surgeons of the United States, Sigma Theta Tau, National Nursing Honor Society, Alpha Kappa Alpha Sorority, Inc., Top Ladies of Distinction, Inc., The ROCKS, Inc., the Order of Military Medical Merit, Past President, Federal Health Care Executives Interagency Institute Alumni Association, and former Board Member of the Bon Secours Health Care System and Chair, Quality Committee.

She is a graduate of the Command and General Staff College and the United States Army War College Fellowship Program at George Washington University, Washington, DC. She is also a graduate of the Johnson & Johnson-Wharton's Fellows Program in Management for Nurse Executives, Wharton School of Business, University of Pennsylvania; Federal Health Care Executives Interagency Institute at George Washington University, Washington, DC; Leadership VA 2004; and Brookings Institute Executive Fellowship Program. She received a BSN from Murray State University and an MS in psychiatric/mental health nursing from Catholic University.

Capt. Darin S. Selnick, USAF (ret.)

Appointed by Speaker of the House John Boehner

Darin Selnick is an independent consultant who provides a variety of services to organizations in the areas of government and community relations, business development, and veterans' issues. He is currently the senior veterans affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation and as the Vice President of Development for the GI Film Festival.

From 2001–2009, Selnick was an appointee at the Department of Veteran Affairs. From 2004–2009 he served as the director of the center for faith-based and community initiatives. In this role he was responsible for the management and operations of the Center and was the VA liaison to the White House Office of faith-based and community initiatives. From 2001–2004 he served as Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University.

Selnick is a retired Air Force officer who attained the rank of Captain. He has been very active in veterans' issues and joined the Jewish War Veterans in 1994. Since that time he has taken various leadership positions and is the past department commander of the Department of California. Mr. Selnick is also a member of the American Legion, AMVETS, Air Force Association, and National Association of Uniformed Services.

Darin Selnick currently serves as senior veterans' affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He lives in Oceanside, CA. Selnick is retired from the U.S. Air Force. He received a BS in health science from California State University, Northridge and an MA in political science/public management from Midwestern State University.

Lt. Gen. Martin Steele, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Martin Steele enlisted in the Marine Corps in January 1965 and rose from private to three-star general, culminating his military career in August 1999 as the deputy chief of staff for plans, policies, and operations at Headquarters, U.S. Marine Corps, in Washington, DC. A decorated combat veteran with 34½ years of service, he is a recognized expert in the integration of all elements of national power (diplomatic, economic, informational, and military) with strategic military war plans and has served as an executive strategic planner/policy director in multiple theaters across Asia. His extraordinary career was chronicled as one of three principals in the award winning military biography, *Boys of '67*, by Charles Jones.

Upon his retirement from active duty in 1999, he served as president and CEO of the Intrepid Sea-Air-Space Museum in New York City. Currently, Steele serves as The Associate Vice President for Veterans Partnerships, the Executive Director, Military Partnerships, and Co-chair of the Veterans Reintegration Steering Committee at the University of South Florida in Tampa, Florida. Additionally, Steele is the chairman and CEO of Steele Partners, Inc., a strategic advisory and leadership consulting company. He has led a philanthropic transition program assisting exiting Marines into private-sector jobs throughout the country, at no cost to the Marine participants, the Marine Corps, or the companies that provide employment opportunities.

Steele serves proudly on several boards across the country. He is currently the Chairman of the Board, Marine Corps Scholarship Foundation. He was appointed to the Board of Directors of Florida is for Veterans, Inc., a not for profit, state legislated organization designed to assist both Veterans and businesses throughout Florida in not only hiring Veterans but also developing entrepreneurship programs designed for veterans. He is a member of Fisher House Foundation;

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chairman of the advisory committee, Stability Institute; advisory committee member, Call of Duty Endowment; advisory board member, Stay in Step Foundation; advisory council member, Operation Helping Hand; member, Veterans Advantage; board member, University of Arkansas Veterans Resource and Information Center; and advisory committee member, Jesse Lewis Choose Love Movement.

Steele is a graduate of the University of Arkansas where he obtained a bachelor's degree in history and was recognized as a distinguished graduate of the Fulbright College of Arts and Sciences. He is a recipient of the 2013 Arkansas Alumni Award Citation of Distinguished Alumni, which recognizes exceptional professional and personal achievement and extraordinary distinction in a chosen field. He also holds master's degrees from Central Michigan University, Salve Regina College, and Naval War College.

Charlene M. Taylor

Appointed by House Minority Leader Nancy Pelosi

Charlene Taylor joined Kaiser Permanente in 1997 as the director of specialty services for the Permanente Medical Group at South Sacramento. In 2002 she became the service director for Kaiser Foundation Hospitals, responsible for perioperative and perinatal services at South Sacramento. In 2008, she was promoted to chief nursing officer at the Sacramento Medical Center where she was responsible for a 287-bed tertiary acute care hospital that conducted more than 11,000 operations per year. There, she oversaw 800 full-time employees and a budget of \$150 million. Taylor was promoted to chief operating officer in 2010 and retired from Kaiser Permanente in 2013.

Before working for Kaiser Permanente, Taylor served as assistant hospital administrator for Sutter Health at the Sutter Amador Hospital from 1988 to 1997. She is a member of the Veterans of Foreign Wars, Reserve Officers Association, and the Society of Air Force Nurses.

Taylor's patriotic and adventurous nature led her to join the Air Force as a reserve officer at the age of 40, rising to the rank of Lieutenant Colonel. She was commissioned as a Captain in the United States Air Force (Reserve Command) in October 1993, earning her flight nurse wings in 1994. She subsequently was selected to be a flight nurse instructor followed by a promotion to evaluator status. Her last squadron assignment was that of chief nurse at the 349 AMDS, Travis Air Force Base.

In addition to years of experience conducting aeromedical evacuation missions throughout the world, Taylor was activated in support of Operation Enduring Freedom from March 2003 to March 2004. In January 2005 she was selected to be the chief nurse of the 379th Expeditionary Aeromedical Squadron in support of Operation Iraqi Freedom. While transporting the injured out of Mosul, Iraq in a C-130, the aircraft took enemy fire, landing without casualties. Due to the demands of her civilian position, Taylor transferred to inactive status in the Air Force Reserve Command. Taylor is the recipient of two Meritorious Service medals, Expert Marksmanship (2), and multiple other medals.

Taylor currently serves on the Veterans Board. In 2012 she was appointed to the Board by Gov. Jerry Brown and approved by the Senate. She became chair in 2014 and continues to serve

in that role. The California Veterans Board serves as an advocate for veterans affairs, identifying needs and working to ensure and enhance the rights and benefits of California veterans and their dependents.

Taylor is a diploma nurse graduate from the Kaiser Foundation School of Nursing. She continued her education receiving a BSN from the State University of New York in Albany, New York. She earned a master's degree in nursing administration from the University of California, San Francisco.

Taylor lives in Elk Grove, CA.

Marshall W. Webster, MD

Appointed by Senate Minority Leader Harry Reid

Marshall Webster is a senior vice president of the University of Pittsburgh Medical Center (UPMC), and a distinguished service professor of surgery at the University of Pittsburgh. A graduate of Penn State University and the Johns Hopkins Medical School, he trained in surgery at the University of Pittsburgh, and subsequently served 2 years as a surgeon on active duty in the U.S. Navy.

Webster returned to the University of Pittsburgh as a faculty vascular surgeon, including initially, a part-time attending staff position at the Pittsburgh VA Medical Center for 3 years. He has held the Mark M. Ravitch Chair in Surgery, and has had a long academic career of clinical practice, research, and service in varied administrative leadership roles. From 2002–2012, he was an executive vice president of UPMC, president of UPMC's physician services division, and president of the University of Pittsburgh Physicians, the clinical practice plan of the university faculty.

His current focus is primarily strategic development: building clinical relationships and care models throughout the region with a large number of community hospitals and providers. Webster has oversight of UPMC's graduate medical education program, which sponsors a substantial number of resident rotations at the Pittsburgh VA Medical Center. He recently served for 2 years as the interim chair of the Department of Anesthesiology at UPMC. He has had a long-standing interest in patient safety and quality initiatives, and recently completed a 6-year term on the board of the Pennsylvania Patient Safety Authority.

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APPENDIX K: COMMISSION STAFF

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DFO – Designated Federal Officer

ADFO – Assistant Designated Federal Officer

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APPENDIX L: ACRONYM LIST

ACRONYM	DEFINITION
ACA	Affordable Care Act
ACHE	American College of Healthcare Executives
APRN	Advanced Practice Registered Nurse
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Capital Asset Realignment for Enhanced Services
CDS	Community Delivered Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CITC	Care in the Community
CMD	Chief Medical Director
CMIO	Chief Medical Information Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
CVA	Concerned Veterans for America
CVCS	Chief of VHA Care System
DAV	Disabled American Veterans
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DHP	Digital Health Platform
DM&S	Department of Medicine and Surgery
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
ECF	Executive Career Fields
EES	Employee Education System
EEO	Equal Employment Opportunity

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ACRONYM	DEFINITION
EHCPM	Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
GHATP	Graduate Health Administration Training Program
GUI	Graphic User Interface
HCD	Human-Centered Design
HEC	Healthcare Executive Council
HPDM	High Performance Development Model
HR	Human Resources
HRA	Human Resources and Administration
HSC	Health Service Category
HTM	Healthcare Talent Management
IAVA	Iraq and Afghanistan Veterans of America
IDIQ	Indefinite Delivery/Indefinite Quantity
IDN	Integrated Delivery Network
IDP	Individual Development Plan
IT	Information Technology
JC	Joint Commission
JEC	Joint Executive Committee
JLV	Joint Legacy Viewer
MSA	Medical Support Assistant
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NLC	National Leadership Council
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations

APPENDIX L
ACRONYM LIST

ACRONYM	DEFINITION
OEF	Operation Enduring Freedom
OGC	Office of General Counsel
OI&T	Office of Information and Technology
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OND	Operation New Dawn
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care
PG	Priority Group
PHS	U.S. Public Health Service
PO	Program Office
PTSD	Posttraumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
RCLF	Relevant Civilian Labor Force
RIF	Reduction in Force
SCI	Spinal Cord Injury
SECVA	Secretary, Department of Veterans Affairs
SE	Senior Executive
SES	Senior Executive Service
SHEP	Survey of Healthcare Experiences of Patients
TBI	Traumatic Brain Injury
TMS	Talent Management System
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACI	VA Center for Innovation
VACO	VA Central Office
VAEB	VA Executive Board

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ACRONYM	DEFINITION
VAMC	VA Medical Center
VERC	Veterans Engineering Resource Center
VFW	Veterans of Foreign Wars of the U.S.
VHA	Veterans Health Administration
VHACO	VHA Central Office
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization
WWP	Wounded Warrior Project



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**THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON**

August 2, 2016

**The Honorable Barack Obama
President
The White House
Washington, DC 20500**

Dear Mr. President:

Two years ago, you tasked me to transform the Department of Veterans Affairs (VA) for the 21st Century. Since then, VA has established a comprehensive, enterprise-wide transformational process named MyVA, which has already increased Veterans' access to health care and begun improving Veterans' experience of VA's benefits and services.

The direction we have taken and the progress we have made has been largely validated by the Commission on Care (Commission) in its Final Report, which VA received on July 7, 2016. After thoroughly reviewing the report, and receiving input from our Veterans Service Organizations (VSOs), I am pleased to say that 12 of the Commission's 18 recommendations are objectives VA has already accomplished or has been working toward for the past two years as part of the MyVA transformation. Although we differ with the Commission on some details and are pursuing alternative approaches where warranted, we agree with the Commission that many changes planned by MyVA, recommended by the Commission, and strongly supported by VSOs, will likely require resources and remedies that only Congress can provide. These issues and our many transformation efforts are summarized in the enclosure to this letter.

VA strongly disagrees with the Commission on its proposed "board of directors" to run the Veterans Health Administration (VHA). Such a board is neither feasible nor advisable for both constitutional and practical reasons. The U.S. Department of Justice has concluded that the Constitution prevents Congress from appointing persons to exercise authority over Executive branch agencies and as such, would prevent the proposed board from exercising the authorities assigned to it by the Commission. The Commission's proposal would also seem to establish VHA as an independent agency, undoing the work of the VSOs in creating VA as a Cabinet-level department. The powers exercised by the proposed board would undermine the authority of the Secretary and the Under Secretary for Health, as well as weaken ownership of the MyVA transformation and VHA performance. This could potentially disrupt and degrade VA's implementation of critical care decisions that affect Veterans. The proposed independent VHA agency would also run counter to our ongoing efforts to improve the Veteran's experience by integrating Veterans health care with the many other services provided to Veterans by the Veterans Benefits Administration and the National Cemetery Administration.

At present, VA is served by 25 advisory committees, including a newly reconstituted Special Medical Advisory Group, which consists of leading medical practitioners and

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The Honorable Barack Obama

administrators, and a newly established MyVA Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates. These advisory committees advise VA on strategic direction, facilitate decision making, and introduce innovative business approaches from the public and private sectors. With their help, the Department has begun the process of transforming VHA from a loose federation of regional health care systems to a highly integrated national enterprise, based on a new model of care with VA as both the payer and provider. This model will provide Veterans with the full spectrum of health care services and additional choice, but without sacrificing VA's foundational health services upon which many Veterans depend. Additionally, many VSOs fear that the Commission's vision would compromise VA's ability to provide specialized care for spinal cord injury, prosthetics, traumatic brain injury, post-traumatic stress disorder, and other mental health needs, which the private sector is not as equipped to provide.

In October 2015, VA submitted to Congress our *Plan to Consolidate Community Care*, which lays out our vision of a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. This plan incorporates feedback from key stakeholders, including VHA field leadership and clinicians, representing diverse groups and backgrounds. VA has already begun what work we can without legislation to make the plan a reality. Over the course of the last 12 months, our Choice Provider Network has grown by 85 percent. The network now has over 350,000 providers and facilities across the Nation. Over 930,000 unique Veterans have used the Veterans Choice Program (VCP). Over 100,000 Veterans with 40-mile eligibility used VCP through May 2016. Authorizations for care under the Veterans Access, Choice, and Accountability Act (VACAA) have increased by 82 percent over 9 months (October 2015 to June 2016), and VCP authorizations have quadrupled from approximately 380,000 in fiscal year (FY) 2015 to almost 2 million in FY 2016.

However, VA cannot accomplish the ongoing transformation through MyVA or recommended by the Commission without critical legislative changes and funding. VA has aggressively pursued these needed changes and funding. As you know, more than 100 legislative proposals for Veterans were included in your 2017 Budget. Many of these proposals are vital to maintaining our ability to purchase community care. We continue to work to move these critical initiatives forward and are encouraged by the fact that most have been considered in legislative hearings or included in omnibus bills moving towards floor consideration, like the bipartisan *Veterans First Act*, which passed the Senate Veterans Affairs' Committee unanimously. These bills include some of the provisions of the *Purchased Health Care Streamlining and Modernization Act* we submitted to Congress in May 2015, such as enhanced-use lease authority, compensation reform for medical professionals, and a measure of budgetary flexibility to respond to Veterans' emerging

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needs and overcome artificial funding restrictions on providing Veterans care and benefits. These provisions would go a long way toward ensuring the success of MyVA, but other important legislative issues still need to be addressed, especially the consolidation of VA's many purchased care authorities and modernization of VA's archaic claims appeals process.

Your strong support for Veterans has been critical to the progress made so far, but VA needs Congress' assistance to make the transformation intended by the Commission and already underway in MyVA to accomplish the changes needed to serve Veterans as they need and deserve to be served now and for generations to come.

Thank you for your continued support of our Nation's Veterans

Sincerely,



Robert A. McDonald

Enclosure

**Enclosure
August 2016**

Department of Veterans Affairs Review of the Commission on Care

Over the past two years, the Department of Veterans Affairs (VA) has been working energetically, through its MyVA initiative, to transform the Veterans Health Administration (VHA) from a loose federation of regional health care systems to a highly integrated national enterprise, based on a new model of care with VA as both the payer and provider. This model will provide Veterans with the full spectrum of health care services, plus more choice, but without sacrificing VA's foundational health services that many Veterans depend on.

In October 2015, VA delivered to Congress a plan for evolving our current system into a high-performance network based on timely access to foundational services and integration of private-sector providers. Building on more than a decade of working with community partners through multiple mechanisms, this plan would consolidate the various mechanisms, expand our network of providers, and enhance the network's capability to deliver services essential to Veterans' health.

Many of the Commission on Care's (Commission) recommendations are aimed in the same direction and are already being implemented as part of VHA's MyVA transformation. VA finds 15 of 18 Commission recommendations feasible and advisable (#1-3, 5-8, 10-16, and 18) and 3 not feasible or advisable (#4, 9, and 17). VA is already implementing changes with the same intent as 12 recommendations (#1-3, 5, 7-8, 10-11, and 13-16); recommends alternative approaches to 2 recommendations to bring them in line with other MyVA reforms (#6 and 12); and will work with the President, Congress, Veterans Service Organizations, and other stakeholders on recommendation #18.

Many of the Commission's recommendations also require action by Congress. VA has aggressively pursued legislative changes and funding that would enable VA to achieve its MyVA vision. More than 100 proposals for legislative changes were included in the President's 2017 Budget. VA also submitted to Congress in May 2015 the *Purchased Health Care Streamlining and Modernization Act*, parts of which have been incorporated into the *Veterans First Act* in the Senate. Many of VA's proposals, which are vital to maintaining our ability to purchase non-VA care, are pending Congressional action.

Recommendation #1: VHA Care System

"Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which Veterans will access high-quality health care services."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach to achieve the vision described above.

In October 2015, VA submitted to Congress its *Plan to Consolidate Community Care*, which lays out our vision of a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. This plan incorporates feedback from key stakeholders, including VHA field leadership as well as clinicians, representing diverse groups and backgrounds.

Immediate steps to improve the stakeholder experience were identified and included in the plan, including reducing unnecessary steps in the processes to enroll and connect Veterans with community care; improving communications between VHA, provider, and Veterans; improving care coordination in the long term for Veterans through improved exchange of certain medical records; and aligning the Veteran's community care journey along five major touch points: eligibility, community care network, referral and authorization, care coordination, and provider claims payment.

Eligibility: The Plan recommends the creation of eligibility criteria to streamline the many different requirements for community care into standard criteria without opening community care to all enrolled Veterans. This is VA's principal point of difference with the Commission on its proposed VHA Care System. VA believes the Commission's recommendation to extend community-care eligibility to all Veterans by eliminating the Veteran Choice Program's (VCP) current time and distance criteria (30 days and 40 miles) is not advisable without Congressional funding due to the expected cost increase and desire to not sacrifice VA's four statutory missions: delivering hospital care and medical services to Veterans, educating and training health professionals, conducting medical and prosthetic research, and providing contingency support to other Federal agencies during emergencies. Many VSOs fear that the Commission's vision would jeopardize VA's ability to provide specialized care for spinal cord injury, prosthetics, traumatic brain injury, posttraumatic stress disorder (PTSD), and other mental health needs, which the private sector is not as equipped to provide. For this reason, VA opposes elimination of the current time and distance criteria.

Community Care Network: VA has since begun developing the requirements for the new community-care network contract, with standards and criteria developed from input by industry, facility staff, and program office staff representing a broad spectrum of needs. These standards and criteria will be included in the draft Request for Proposal (RFP) for the community care network that will open for bid later in calendar year 2016. **Legislation is needed** to improve Veterans experience by consolidating existing programs and standardizing eligibility criteria.

Referral and Authorization: To ensure that Veterans have access to the full spectrum of health care services, VA will focus on areas in which it can excel (VA-delivered foundational health services) and develop locally defined community partnerships for specialty care as needed. Standards and criteria for specialty care referrals are currently being developed for inclusion in the draft RFP. While the primary care provider will coordinate referrals for specialty care within the integrated VHA Care System, VA should be seen as the prime provider for special emphasis services. For example, VA is the leader in integrating primary care and mental health care and should be seen as the primary care provider for these services. When VA cannot provide a primary care provider, Veterans will be able to select from credentialed providers in the high-performing network.

Care Coordination: The Plan stresses care coordination with a focus on customer service, emphasizing the need for care coordination for Veterans who receive community care as well as in VA. This coordination would include both the primary care provider staff as well as other VA staff. In cases where VA cannot provide the care coordination for Veterans, the services may be provided through the community care network. In other cases, VA coordinators make more sense. This is true in the Alaska VA Healthcare System, where VA staff will fill an intermediary role currently performed by VCP contractor TriWest to make scheduling an inherently VA activity, in response to local concern that calling out-of-state VCP contractors resulted in delays in care coordination, mostly attributed to time-zone differences and a lack of understanding of Alaska's unique geography.

Provider Claims Payment: VHA is also already working to streamline reimbursement methodologies among its various community care programs and to develop a standardized, transparent process for reimbursing providers in an integrated delivery network. VHA and the Centers for Medical and Medicaid Services (CMS) are identifying CMS innovations in value-based payment methods on a limited basis. **Legislation is needed** to revise reimbursement rates under the Veterans Access, Choice, and Accountability Act to allow for flexibility from Medicare fee-for-service reimbursement methodologies to value-based methodologies of the future.

Legislation is needed to effectively consolidate existing community care programs, which would reduce confusion among Veterans, community providers, and VA staff. The Commission states that in order to achieve the recommendations, VA must have "flexible and smart procurement policies and contracting authorities." VA strongly agrees and has aggressively pursued legislative changes that would ensure that the appropriate level of flexibility is available to best serve Veterans. In May 2015, VA submitted the *Purchased Health Care Streamlining and Modernization Act* to Congress. This legislation supports key points of VA's *Plan to Consolidate Community Care* and would allow VA to enter into agreements with individual community providers outside of Federal Acquisition Regulations, without forcing providers to meet excessive compliance burdens.

VA is also concerned that the Commission's cost estimates do not accurately reflect the likely cost of its proposed system. From a baseline estimate of \$71 billion, the Commission estimates that the cost of its recommended option for Veterans' health care for fiscal year (FY) 2019 ranges from \$65 billion to \$85 billion, with a middle estimate of \$76 billion. However, the Commission estimates the cost could increase to \$106 billion in FY 2019 if VA is unsuccessful in tightly managing the network and focusing on costs. We appreciate the analysis underpinning the Commission's estimates, but caution that the cost of implementing the Commission's recommendation is likely to be significantly higher, for the following reasons:

- The estimates do not include the substantial investment in information technology (IT) resources that would be required to fully integrate VA care with community care or the administrative/contractual costs of operating the community-delivered services component of the integrated network.
- The estimates assume that VA can realign and consolidate personnel in five years to best provide health care to Veterans, which is an aggressive timeline.

- The estimates do not address the cost of realigning or divesting capital assets as additional care is delivered in the community. While VA agrees in principle with the Commission's recommendation to develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs (see Recommendation #6), we note that the realignment, consolidation, and divestiture of capital assets will require substantial resources and time.
- The estimates are highly dependent on Veteran enrollment in, reliance on, and utilization of VA health care, all of which are difficult to predict, as most Veterans enrolled in the VA health care system have other sources of health care coverage. Extending community care to more Veterans could cause Veterans who now rely on Medicare, Medicaid, or private insurance to use VA care for more of their health care needs because of lower copays or greater convenience, increasing VA's costs.
- Finally, we must caution that the estimates do not reflect the entire VA Medical Care budget as they do not include the cost of programs that are not modeled by the VA Enrollee Health Care Projection Model. These programs include readjustment counseling, non-medical homeless programs, Caregivers, Health Professions Educational Assistance Program, Income Verification Match, CHAMPVA, Spina Bifida, Children of Women Vietnam Veterans, etc. In total, they are estimated to cost \$8.2 billion in FY 2017.

Recommendation #2: Enhancing Clinical Operations

“Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VHA is already engaged in processes to make full use of the skills held by VHA providers and other health professionals. VHA is a leader in the use of clinical pharmacists to increase capacity by renewing prescriptions or ordering medication refills independently, after the initial prescription by a licensed physician or nurse practitioner. In addition, many VA clinical pharmacists have a scope of practice that provides prescribing authority and enables them to run pharmacist-managed clinics focused on medication therapy management for chronic diseases. For example, about one third of all prescriptions for the treatment of the Hepatitis C virus are written by clinical pharmacists

VHA has also developed a draft regulation that would standardize full practice authority for advanced practice nurses, to assure a consistent continuum of health care services by the practitioners across VHA and decrease the variability in advanced nurse practice that currently exists as a result of disparate State practice regulations. The proposed draft regulation was published in the *Federal Register*; we are now reviewing comments

received. Implementation of full practice authority will increase Veteran access by alleviating the effects of national health care provider shortages on VA staffing levels and enabling VA to provide additional health care services in medically under-served areas. Implementing this policy, as recommended by the Commission, will allow VA to parallel the policies of other Federal agencies, including the Department of Defense (DoD) and the Indian Health Service, as well as many institutions in the private sector.

VHA's Diffusion of Excellence initiative is an operational infrastructure that allows for sharing of promising practices across the enterprise. This model incentivizes and institutionalizes the identification and diffusion of practices nationwide so that every facility has the opportunity to implement the solutions that are most relevant to them. In the first round of submissions, 13 Gold Status Best Practices were selected from more than 250 ideas through a series of reviews and a final "Shark Tank" competition. The next step assigned each Gold Status Best Practice and their originating Gold Status Fellows to Action Teams managed by the Diffusion Council for implementation VHA-wide.

VA seconds the Commission's call for Congress to relieve VHA of bed-closure reporting requirements under the Millennium Act. The Act's arbitrary requirements have not kept up with changes in the Veteran population or the health care environment. **Legislation is needed** to remove the Act's bed change reporting codified at 38 U.S.C. 8110(d) and the staffing level and service requirements specific to such bed changes under section 38 U.S.C. 1710B(b), while retaining staffing and service requirements for all other Extended Care Services. VA would replace the mandated congressional reporting of bed closures with a stronger, clearer, and more stringent internal process to review and if appropriate, approve bed closure proposals.

VA is already moving forward to hire and train more clinical managers and medical support assistants (MSAs). In response to Section 303 of the Veterans Access, Choice, and Accountability Act of 2014 (PL 113-146), each VA Medical Center now has a Group Practice Manager (clinical manager). Additional hiring and training of these group practice managers will continue through February 2017. VHA is also developing new training and hiring procedures for MSAs throughout the organization as part of MyVA. VA has developed and launched an MSA hiring project called "Hire Right, Hire Fast" and is currently piloting a new hiring procedure that allows for industry-standard bulk hiring of MSAs to hire MSAs within 30 days of a vacancy. Two-week, standardized onboarding training for all new MSAs is also being developed and piloted. Both new processes will begin being deployed nationally this fall.

Recommendation #3: Appealing Clinical Decisions

"Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach, taking into account important differences between the mission and authority of the VA health care system and other Federally-supported programs.

VHA is already in the early stages of developing a regulation in response to the Commission's recommendation. This regulation will establish a cohesive baseline national policy for clinical appeals. A clinical appeals regulation will be published for notice and comment in accordance with the Administrative Procedure Act. Recently enacted legislation in section 924 of the Comprehensive Addiction and Recovery Act of 2016 establishes an Office of Patient Advocacy in the Office of the Under Secretary for Health. In addition, in 2015 VHA established the Office of Client Relations to assist Veterans clinical care access concerns.

An interdisciplinary panel will be tasked with evaluating feedback from these offices and other Veteran support resources to improve the overall clinical appeals process, consistent with external benchmarks and factors described by the Commission, Federal regulations and statutes, and sound clinical practice. The resulting recommendations may differ in certain aspects from those envisioned by the Commission, but will undoubtedly be a uniform, fair, world-class clinical appeals process that protects Veterans and is fully compliant with law and regulation. VA's revised process will complement the Veterans Experience Office's efforts to better serve Veterans, make improvements based on customer feedback, and engage the community.

Recommendation #4: Consolidation of Improvement Efforts

“Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.”

VA finds this recommendation neither feasible nor advisable, but is already implementing an alternative approach that institutionalizes continuous improvement as part of VA's MyVA transformation.

Health care improvement takes place within a complex socio-technical system with multiple aspects of technology and technical expertise. Placing improvement under an engineering system, such as the Veterans Engineering Resource Center (VERC), may harness the technical aspects of improvement, but it will not provide the balance of critical cultural and people aspects. VA believes doing so would unbalance safety and efficiency and not be successfully transformational.

Ongoing VA transformation efforts have been achieved by specifically aligning VERC assets with enterprise priorities so that appropriate engineering perspectives and skills are interwoven with current organizational priorities. To institutionalize VHA's commitment to continuous improvement, VHA will realign the VERC and the operational improvement arm of Strategic Analytics for Improvement and Learning (SAIL) under the Principal Deputy Under Secretary for Health. This will elevate the health-system subject matter experts who drive transformation in VHA's organizational structure, while continuing to use the VERC to ensure that supporting engineering resources are available across all VA transformational efforts.

Additionally, VA's enterprise approach to improving performance—through Lean Six Sigma (Lean) tools and training, Leaders Developing Leaders training, MyVA Performance Improvement Teams, MyVA Communities, the MyVA Ideas House, and many other initiatives across the VA system—has taught us the value of a central repository for local programs and ideas, both successful and unsuccessful. To that end, VA and VHA have embraced the Integrated Operations Platform (IOP) hub, a knowledge-management technology platform developed by the VERC in partnership with subject matter experts. The IOP consolidates information on continuous improvement activities across VA in key programs, and as a result, best practices and innovation activities are currently visible in one common platform.

VA has invested significantly in developing Lean capacity at local levels so that problem solving is done at the lowest level and with a team of safety, quality, and improvement professionals. This prepares the local facilities to improve their current environment while scanning constantly for emergent new problems.

Recommendation #5: Eliminating Healthcare Disparities

“Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.”

VA finds this recommendation feasible and advisable and is already working to address each of the Commission's concerns as part of VA's MyVA transformation.

VA's Office of Health Equity (OHE) was established in 2012 with the mission of championing health equity among vulnerable Veterans. The office developed the Health Equity Action Plan (HEAP) in 2014 in conjunction with the Health Equity Coalition and with concurrence from the Under Secretary for Health. The HEAP is VHA's strategic roadmap to reducing Veteran health disparities. It aligns with the goals of MyVA and the VHA Strategic Plan. VHA will make health equity a priority by directing implementation of the HEAP nationwide.

The appropriate placement of OHE within the VHA organizational structure, along with adequate resources, will be considered as a priority component of the broader VHA restructuring addressed in Recommendation 12. This will take into account funding and staffing levels commensurate with the scope and size of Federal offices of health equity established in the Department of Health and Human Services, based on direction in the Affordable Care Act. VA will also identify health equity leaders and clinical champions in each VA District, Veteran Integrated Service Network (VISN), and Medical facility who can catalyze and monitor actions to implement the HEAP and further advance the elimination of health disparities.

VA has undertaken systematic actions to identify and address healthcare disparities and inequality. Examples include the development of Hepatitis C Virus Disparities dashboard projected, scheduled for launch by the end of FY 2016; data support and research collaborations with the Quality Enhancement Research Initiative designed to identify health care disparities; establishment of a Population Health office that has developed clinical case

registries focusing on the needs of special populations; and establishment of the Women's Health and Lesbian, Gay, Bisexual, Transgender (LGBT) program offices. VA Medical Facilities constitute 20 percent of Human Rights Campaign's Health Care Equality Index participants in 2016, and they were the only facilities to achieve leader status in some States.

Recommendation #6: Facilities and Capital Assets

“Develop and implement a robust strategy for meeting and managing VHA’s facility and capital asset needs.”

VA finds this recommendation feasible and advisable but recommends alternative approaches as part of VA’s MyVA transformation.

VA believes that the Commission's recommendation is critical to enabling the successful transformation of the large-scale health care system to a higher-performing integrated network to serve Veterans. Without a strong suite of capital planning programs, tools, and resources, VA will not be able to fully realize the benefits and Veteran outcomes expected from implementing an integrated health care network. VA also strongly agrees with the Commission that greater budgetary flexibility and greater statutory authority are essential to meeting VA’s facility needs, realigning VA’s capital assets, and streamlining processes to divest itself of unneeded buildings.

VA recommends alternative approaches to two issues:

- Once VA determines its mix of health care services and how they are provided at the market level based on the integrated health care approach, realignment of VA’s capital infrastructure framework will be needed. Instead of a realignment process encompassing both assets and services based on DoD’s Base Realignment and Closure Commission, VA proposes an independent facilities realignment commission (IFRC) to focus solely on VA’s infrastructure needs once the mission services are determined. The IFRC would develop a systematic capital-asset-focused realignment plan for infrastructure needs to be presented to the Secretary of Veterans Affairs and the President for decision, with Congress approving or disapproving the plan on an up-or-down vote.
- With regard to focusing new capital on ambulatory care development, VA proposes a balanced approach to maintain needed infrastructure and other key services (e.g., rehabilitation, community living centers, and treatment for spinal cord injury, traumatic brain injury, polytrauma, and PTSD), while at the same time appropriately investing in ambulatory care in needed markets. The balanced approach would be based on a market-by-market determination of the appropriate mix of services to ensure Veterans have access to needed care.

VA agrees with the recommendation to move forward immediately with repurposing or disposing facilities that have already been identified as being in need of closing. Continued focus in this area is needed and VA is already working towards this goal, subject to the availability of staff and resources.

VA also acknowledges that there will be anticipated challenges in implementing such large-scale realignments and restructuring of VA's footprint. **Legislation will likely be required** facilitating changes to VA's capital infrastructure to implement a transformation of this nature, including:

- Establishing an IFRC to develop a systematic capital-asset-focused realignment plan.
- Streamlining processes to meet the intent of laws and regulations, such as the National Historic Preservation Act and the National Environmental Policy Act that would make repurposing and divestiture more timely and effective.
- Potentially restructuring appropriations to allow for more flexible transfer and reprogramming authority, including potential threshold adjustments.
- Exploring methods (both legislative and administrative) to take advantage of private-sector financing.
- Revising the major medical lease authorization process to align the requirements in concert with practices at other Federal agencies.
- Granting VA authority to retain and utilize proceeds generated from real property divestitures.
- Expanding enhanced-use leasing authority.

Further analysis will be required to determine the specific level of resource investments required to implement the Commission's recommendations. It is clear that significant additional resources will be required. In addition, divestiture of unneeded VA assets is unlikely to generate significant savings because of the upfront resources required to execute the divestiture and minimal market value of the majority of VA's assets. Without the proper resources, tools, and authorities, attempts to divest of assets or streamline capital project execution will not be effective.

Recommendation #7: Modernizing IT Systems

“Modernize VA’s IT systems and infrastructure to improve veterans’ health and well-being and provide the foundation needed to transform VHA’s clinical and business processes.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach, understanding that investments in IT will force difficult decisions concerning the allocation of limited financial resources among all VA programs and services, as well as across the Federal government.

As part of the MyVA Breakthrough Initiative to transform VA IT, VA will soon appoint a Senior Executive System (SES)-equivalent position for a Chief Health Informatics Officer (CHIO), reporting to the Assistant Deputy Undersecretary for Health for Informatics and Information, to collaborate with the VA Chief Information Officer (CIO) and the IT Account Manager toward developing a comprehensive health IT strategy and supporting budget proposal. The CHIO and ADUSH will be responsible for prioritizing all health technology

programs and initiatives, with strategic technological guidance from the VA CIO and IT Account Manager for health. To comply with the Federal Information Technology Acquisition Reform Act (FITARA), the CHIO does not take the place of the VA CIO, but instead works in concert with IT management to ensure that health initiatives are appropriately prioritized within the portfolio, while the CIO works with VA senior leadership so that all technology initiatives are prioritized holistically, thus ensuring complete Veteran care. VHA and VA's Office of Information and Technology (OI&T) are already collaborating on the vision and strategy for a single integrated Digital Health Platform (DHP).

VA has also established five district senior-executive Customer Relationship Manager positions to work with the local VHA, Veterans Benefits Administration, National Cemetery Administration, and staff office leaders, aggregate feedback for analysis by VHA and OI&T senior leadership, and enhance a continuous feedback loop. The VA CIO recently established the Veteran-focused Integration Process program within the Enterprise Program Management Office (EPMO) to facilitate continuous improvement and constant collaboration.

The Commission recommended that the VA CIO develop and implement a strategy to allow the current nonstandard data to effectively roll into a new system, and engage clinical end-users and internal experts in the procurement and transition process. VHA is currently working with OI&T to ensure that the Veterans Information Systems and Technology Architecture (VISTA) data is mapped to national standards. The new CHIO will be responsible for engaging clinical end-users in the transition to the new DHP. The Under Secretary for Health and the CIO will establish a joint program office responsible for the implementation of the DHP. This process will be focused on delivering and coordinating high-quality care for Veterans.

The EPMO is responsible for portfolio management and has adopted a policy of "best-fit, buy-first" in its Strategic Sourcing function. This ensures that existing best-in-class technology solutions are purchased whenever possible, rather than being developed and maintained by VA. These functions, in combination with the role and focus of the IT Account Manager, will provide the required focus for VHA to implement a comprehensive commercial off-the-shelf IT solution to include clinical, operational, and financial systems.

Recommendation #8: Modernizing Supply Chain

"Transform the management of the supply chain in VHA."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VA believes the components of this recommendation that suggest establishment of a Chief Supply Chain Officer (CSCO) and realignment of all procurement and logistics operations under the CSCO executive position are feasible and advisable, but it recommends an alternative approach to fulfill the Commission's intent. The structural solution recommended by the Commission would not adequately address underlying management challenges associated with organizational complexity and the need to improve integration processes

impacting the supply chain. Realignment of VHA's supply-chain structure, including roles and responsibilities of the various VA Central Office staff offices, health networks, and medical facilities, should derive from and be integrated with the transformation of the overall VHA health care organization structure. The intent of the Commission will be met by addressing alignment issues as the supply-chain breakthrough initiative evolves and is synchronized with VHA's overarching strategies to transform VHA's organizational structure.

As an alternative, the intent of the Commission is already being addressed in an effective manner under the current MyVA Breakthrough Initiative to transform VHA's supply chain. This initiative is a more comprehensive approach to fulfilling the Commission's intent and is already driving much needed improvements in data visibility and quality, synchronization of technology deployments, standardization, contract compliance, and training. Already in FY 2016, VHA supply-chain transformation efforts have yielded approximately \$45 million in cost avoidance. VHA has also developed a two-year supply-chain transformation stabilization guidance that will put VHA in a far better position to make effective decisions and investments beyond FY 2018 for vertically aligning VHA's management structure and for more efficient sourcing and distribution of all clinical supplies and medical devices. This will increase the availability of supplies for the care of Veterans and result in cost avoidance for American taxpayers.

With regard to the component of the recommendation asking VA and VHA to establish an integrated IT system to support business functions and supply-chain management, although feasible it is more advisable that technology investments beyond those currently in the pipeline should be avoided until such time that a mature supply-chain baseline is established, upon which prudent future IT investment decisions can be based. This is especially important given VA's Financial Modernization System initiative and emerging plans for a new DHP, both of which will impact legacy and contemporary supply-chain systems and interfaces, as well as influence system-improvement alternatives and investment decisions over the next two to five years. Supply-chain system improvements must be integrated and synchronized with enterprise financial and health care system enhancements to achieve efficiencies in service delivery and support analysis of integrated data to meet VHA's current and future needs.

Finally, as suggested, VHA will continue to use VERC capabilities to support the transformation of supply-chain management in accordance with the MyVA Breakthrough Priority Initiative #12: VHA Supply Chain Transformation. As a point of clarification, the Commission report is technically incorrect in that the VERC is not leading the MyVA supply-chain modernization initiative; rather, the VERC is a highly valued enabling organization engaged by the VHA Procurement and Logistics Office to support the MyVA initiative.

Recommendation #9: Governance Board

"Establish a board of directors to provide overall Veterans Health Administration (VHA) Care System governance, set long-term strategy, and direct and oversee the transformation process."

VA finds the Commission's recommendation neither feasible nor advisable due to its unconstitutionality. However, VA believes the intent of the Commission can be achieved regarding the term appointment of the Under Secretary for Health.

The U.S. Department of Justice has concluded that the proposed board of directors, as appointed and with the powers proposed by the Commission, would be unconstitutional for several reasons. Permitting Congress to appoint the board members would violate the Constitution's Appointments Clause (U.S. Const. art. II § 2, cl. 2), as well as the separation of powers, insofar as congressionally appointed board members would be exercising significant operational authorities within the Executive Branch. In addition, giving this board authority to reappoint the Under Secretary for Health would violate the Appointments Clause and the separation of powers. Finally, requiring the board to concur with the President in removing the Under Secretary for Health would give the board a veto authority over the President, impairing the President's ability to "take Care that the Laws be faithfully executed," (U.S. Const. art. II, § 3), and violating the separation of powers.

The proposed board would also seem to separate VHA from VA without necessarily insulating VHA from political pressure or improving VHA oversight or operations. The powers exercised by the proposed board would undermine the authority of the Secretary and the Under Secretary for Health and weaken ownership of the MyVA transformation and VHA performance, potentially disrupting and degrading VA's implementation of critical care decisions affecting Veterans. The independence granted VHA would run counter to our ongoing efforts to improve the Veteran's experience by integrating Veterans health care with the many other services VA provides through the Veterans Benefits Administration and the National Cemetery Administration. Furthermore, VA is already advised by the Special Medical Advisory Group, which consists of leading medical practitioners and administrators, and by the MyVA Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates with diverse expertise in customer service, strategy development and implementation, business operations, capital asset planning, health care management, and Veterans' issues. These committees already provide VA with outside expert advice on strategic direction, facilitating decision making and introducing innovative business approaches from the public and private sectors.

The Commission correctly notes that frequent turnover of the Under Secretary for Health has had a negative impact on VHA and greater stability in this important leadership position is needed. VA supports a term appointment of the Under Secretary for Health spanning Presidential transitions to ensure continuity of leadership and continued transformation of VHA. Previously, 38 U.S.C. § 305 provided for a four-year term for the Under Secretary for Health with reappointment possible, but this provision was removed in 2006. A term appointment could be reinstated, beginning with the current Under Secretary for Health. This is critically important at this juncture given the need to see the ongoing transformation of VHA through to completion. Under Secretary for Health candidates are currently recommended by a commission established solely for that purpose. More analysis is needed to determine length of tenure and timing of reappointment.

Recommendation #10: Leadership Focus

“Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA’s MyVA transformation, with some modifications in approach.

Recent or ongoing actions serving the Commission’s intent include:

- VA has established the MyVA Task Force to guide VA through the transformation and established a Department-wide MyVA transformation office, which has formulated an integrated plan for transformation and is organizing the work on 12 breakthrough priorities.
- Metrics and key performance indicators are in place for each breakthrough priority. Each breakthrough priority has a designated, accountable official who is a member of the senior leadership team and a near-full-time responsible official in charge of driving progress.
- One of the 12 breakthrough priorities in the MyVA Transformation is employee engagement, for which we have a comprehensive action plan.
- VA has also established a MyVA Advisory Committee (MVAC) consisting of business leaders, medical professionals, government executives, and Veteran advocates. VA leadership meets quarterly with the MVAC, leveraging them as a corporate board from which to seek counsel on the overall transformation.
- MyVA has engaged leaders and employees throughout the organization via Leaders Developing Leaders (LDL) (over 54,000 participants to date), VA101 (over 79,000 participants to date), various skills trainings, LDL projects, breakthrough pilots, broad communications to include the MyVA Story of the Week that goes out every Friday to all employees, and local initiatives.
- VA established MyVA district offices to facilitate transformation efforts throughout VA and also now conducts quarterly surveys of the VA workforce and incorporates this feedback into VA’s transformation actions.
- Secretary, Deputy Secretary, and Under Secretary for Health have provided role models for transparency, Veteran focus, and principles-based leadership.
- VHA programs and program offices and the Office Human Resources & Administration (HR&A) representatives have held regular meetings in the past year to discuss a single, benchmarked concept for organizational health and coordinate messaging.
- VHA’s National Leadership Council has endorsed personalized, proactive, patient-driven healthcare as one of VHA’s strategic goals and strongly supported the formation of organizational health councils.
- Many VHA facilities and networks have some version of an organizational health council already existing.
- All program offices and facilities receive employee survey data annually down to the workgroup level to facilitate action planning and improve employee engagement. Brief pulse surveys have recently been implemented to measure employee engagement at the facility level quarterly.
- VHA’s National Center for Organizational Development has use of Prosci change management materials and is pursuing a system-wide license.

Recommendation #11: Leadership Succession

“Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA’s MyVA transformation, with some modifications in approach.

VA is consolidating leadership training behind a model we created as part of our MyVA transformation called ILEAD. Previously, VA had multiple leadership models across VA, which led to no common language or culture of leadership, and the models were not customized for VA. The enterprise-wide ILEAD model will incorporate the principles of “servant leadership” and VA’s ICARE core values, aligned with the Federal Executive Core Qualifications. VHA and the VA Corporate Senior Executive Management Office are in the first stages of developing a competency model for VHA’s senior leadership positions that will incorporate VA’s ILEAD model with the technical competencies essential to successfully leading VHA’s complex clinical operations. The VHA senior leader competency models will ultimately cascade down through the organization and be incorporated in its hiring, development, performance assessment, and advancement programs.

VHA has outlined a leadership talent management strategy, benchmarked against the best practices in private industry, and begun initial development of processes and tools to give VHA greater insight and control over its health care leadership succession pipeline. Initial efforts are focused on creating a cadre of leaders to fill future medical center director positions. At the individual level, VHA senior executives serve as mentors to staff members, coaches for VHA leadership development programs, and models through their own leadership behavior.

Current VHA initiatives serving the Commission’s intent include:

- VHA made leadership development a priority of its MyVA effort, specifically to *develop and retain passionate leaders* to lead transformational efforts across the Administration.
- Filling key leadership position through a strong succession pipeline is identified as a priority for VHA in the 2016 *VHA Workforce and Succession Strategic Plan*.
- VHA has fully embraced the LDL philosophy—nearly 30,000 VHA employees have participated in the leader-led cascaded training since it began in September 2015.
- VHA’s National Leadership Council has adopted the VA leadership model, which now includes the concept of “servant leader.”
- VHA leaders are integrally involved in the development and conduct of its formal leadership development programs. Leaders serve as coaches and mentors to program participants, in addition to personally facilitating sessions on a wide variety of leadership topics.
- VHA established the Healthcare Leadership Talent Institute (HLTI) to provide coordinated focus to VHA’s talent management efforts. HLTI links VHA’s workforce-planning and talent-development programs through the design and

deployment of a set of talent management products and processes, which are in the pilot-testing phase.

- VHA is collaborating with the VA Corporate Senior Executive Management Office in implementing the December 2015 Executive Order on *Strengthening the SES*. These efforts include building a foundational leadership competency model for VA, instituting an executive rotation program to provide career-broadening experiences outside of each executive's current position, enhancing the SES performance management system, and outlining an SES-level talent-management process for VA-wide implementation.

Recommendation #12: Organizational Structures and Management Processes

“Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.”

VA finds this recommendation feasible and advisable but recommends an alternative approach to reorganizing the VHA Central Office (VHACO), consistent with VA's MyVA transformation.

VHACO has undergone a stepwise ascent to improving the organizational structure to be more responsive to field requirements through the development of large programs responsible for organizational excellence and developing the future state health care plan. Immediate reorganization would divert attention from key organizational priorities such as improving access to healthcare. Known challenges associated with reorganization (which occurs with the regularity of each presidential election cycle), are impaired employee engagement, loss of institutional knowledge, and diversion of attention from critical challenges such as insuring Veterans have same-day access to primary care and mental healthcare services. **Legislation would be required** to streamline appropriations, and review by oversight bodies would be impacted by the changes described. Finally, the reorganization for VHACO should derive from and be integrated with the transformation of the overall VHA health care organization structure. VHA will initiate a VHACO and VISN organization analysis at the beginning of calendar year 2017.

Recommendation #13: Performance Measurement

“Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.”

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's MyVA transformation, with some modifications in approach.

VHA is consolidating its healthcare operations metrics to provide a consistent, system-wide view of key performance indicators. In October 2015, VHA launched a Performance Accountability Work Group (PAWG) as a governance mechanism for performance measurement at all levels of the organization. The PAWG's first task was to conduct a systematic review of all existing performance measures (numbering over 500), which resulted in a core set of approximately 20 key indicators, aligned to industry-wide approaches. SAIL scoring system is a critical component of these indicators, as well as predictive trigger systems that are the main inputs into a health operations center, which will facilitate centralized quality management.

The leadership of the Office of Organizational Excellence (hereafter, 10E) has undertaken a strategic review across all current business processes to identify realignment opportunities—for instance, focusing ISO 9000 on its original target, which was the reprocessing of reusable medical equipment, and reinvesting the resources that will be freed up to enhance the ability of VERC to support the adoption of LEAN management approaches in support of the Under Secretary for Health's five priorities for strategic action.

We have also engaged a senior industry consultant to assist us with the process of executive recruitment and development; created a system-level VHA Performance Scorecard aligned along transformational priorities; simplified the template used for senior healthcare executive performance management plans; and started work to align business functions within the Office of Organizational Excellence to promote a unified approach to performance reporting, performance improvement, and the identification and spread of strong clinical and business practices.

Finally, the Diffusion of Excellence initiative (see Recommendation #2) sources best practices from frontline employees in the field, and brings the combined resources of 10E to support their implementation where appropriate in under-performing VA sites.

Recommendation #14: Cultural and Military Competence

“Foster cultural and military competence among all Veterans Health Administration (VHA) Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health care outcomes.”

VA finds this recommendation feasible and advisable and is already working to address the Commission's concern as part of VA's MyVA transformation.

VA has implemented training related to cultural and military competence, in some cases by partnering with external stakeholders (i.e., Equal Employment Opportunity Commission, the Joint Commission, Commission on Accredited Rehabilitation Facilities, DoD) and numerous national diversity-focused affinity and advocacy organizations. Examples of this coordinated training include Military Culture Training for Community Providers, Cultural Competency, Generational Diversity, Introduction to Military Ethos, Military Organization and Roles, Professional Stressors & Resources and Treatment Resources & Tools. From April 1, 2015, to July 22, 2016, the last four courses were accessed 2,533, 1,527, 1,172, and 1,070 times respectively. VA will continually assess its cultural and military

competence training portfolio for content, target audience, and training modalities to identify additional training needs.

VA Office of Diversity and Inclusion has mandatory training in the area of cultural competence as part of its Equal Employment Opportunity (EEO), Diversity and Inclusion, and Conflict Management training for all VA managers and supervisors and mandatory annual EEO, Workplace Harassment, and No FEAR training for all VA employees. VA also maintains programs focusing on targeted populations, including a LGBT Awareness Program (issues referenced in the Report), Office of Women's Health Services; Office of Health Equity; and a Center for Minority Veterans.

VHA also has a large portfolio of clinical training programs, including several in the area of cultural and military competence in healthcare delivery. The Office of Health Equity developed virtual patient cultural competency training under the Employee Education Service contract for the Virtual Medical Center project. Presently, military competence training is available to any provider, and they are encouraged to take the training. Providers currently under contract are not required to complete the course, but future contracts will require completion.

Recommendation #15: Alternative Personnel System

“Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.”

VA finds this recommendation feasible and advisable and is already working as part of VA's MyVA transformation, with some modifications in approach

VA supports the Commission's legislative proposal recommendation to establish a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority, provided outside stakeholders support the legislative and policy changes required to create this new system.

VA currently is preparing for consideration a legislative proposal for the FY 2018 budget process to modify 38 United States Code to give the Secretary the authority to establish a human-resources management system unique to VA.

In the absence of a simple-to-administer alternative personnel system, VA has also proposed modifications to existing statutes to provide some relief to the currently complex personnel system and also help with recruitment and retention. These proposals include establishing an appointment and compensation system under Title 38 for VHA occupations of Medical Center Director, VISN Director, and other positions determined by the Secretary that have significant impact on the overall management of VA's health care system. VA is considering proposals to do the following:

- Eliminate Compensation Panels for physicians and dentists, which have been found to be administratively burdensome.
- Eliminate performance pay for physicians and dentists, which has been found to be extremely difficult to administer.
- Establish premium pay for physicians and dentists to allow flexibility in scheduling and eliminate the daily rate paid to these occupations based on 24/7 availability.
- Modify special rate limitation to increase the maximum allowable special rate supplement providing enhanced flexibility to pay competitively within local labor markets.
- Exempt VHA health care providers appointed to positions under 38 U.S.C. 7401 from the dual compensation restrictions for reemployed retired annuitants.

The VHA Strategic Human Resource (HR) Advisory Committee and Workforce Management and Consulting's Human Resource Development group are proposing a comprehensive VHA HR Readiness Program designed to improve the overall operational capabilities of the VHA HR community. The program will identify and integrate all existing and available internal and external training resources into a clear, consistent, and logical roadmap to readiness.

Under the MyVA program, the Staff Critical Positions Initiative was launched to improve hiring of key leadership and other critical positions throughout VHA. VHA is moving ahead with the "Hire Right, Hire Fast" initiative for MSAs. The initiative is being piloted at a number of facilities and will provide products and guidance in 2016, including additional screening for customer service tools, an interview scoring rubric, job posting templates, HR milestone scripts, and much more. These products are designed to increase the supply of MSAs, as well as emphasize the customer service principles and skills needed for success.

VHA has embarked on a Rapid Process Improvement Workshop effort within the HR community to examine the hiring process and identify improvement opportunities, to include operational processes and policies. Plans are also under development to establish a centralized architecture to designate lines of authority in setting training requirements, career paths, etc.

Recommendation #16: Effective Human Capital Management

"Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system."

VA finds the Commission's recommendation both feasible and advisable and is already pursuing the following initiatives as part of VA's MyVA transformation.

Hire Chief Talent Leader and Grant Authorities: VHA currently has a national search underway for its senior most HR executive position. Presently that role does not possess the authority recommended by the commission. It is anticipated that the HR&A transformation program, and the efforts associated with Recommendation 12 in conjunction with the Under Secretary for Health, would work together toward the optimal organization

structure for HR across VA and within the administrations including appropriate authorities. This process will help clarify the ideal roles and responsibilities of the VHA Chief Talent Leader.

Transform Human Capital Management: As part of MyVA, VA HR&A has launched the Critical Staffing Initiative to improve the hiring of key leadership and other critical positions throughout the VA. This effort has been working on near-term improvements to hiring medical center directors and other key medical center leaders. So far, this project has identified and is beginning to implement significant improvements to the hiring process and to proliferate hiring best practices across the organization. VA HR&A is currently planning a process to engage stakeholders across VA to identify next steps for implementing the recommendations outlined in recent study commissioned by VA. A concept paper entitled “VISN HR Shared Service Excellence” is also being evaluated. This concept paper incorporates a number of recommendations contained within the white paper noted above, but with specific emphasis on HR roles within the VISNs and VA Medical Centers. The Commission’s recommendations will be taken into consideration in the process.

Implement Best Practices: The VISN HR Shared Service Excellence paper is heavily weighted toward the sharing of best practices that have been developed in a few highly performing field HR organizations. Best practice sharing is also a significant component of the MyVA Critical Staffing initiative. Also, the HR&A transformation effort is intended to rely heavily on health care and other industry best practice models.

Develop HR Information Technology Plan: The Commission’s recommendation addresses an issue which VA’s early HR transformation efforts are just beginning to address. While there are currently efforts planned and underway to implement HR Smart for personnel and payroll records, and USA Staffing to enable the recruiting process (acknowledged by the Commission), VA would benefit from casting these and other anticipated efforts in a more strategic IT plan. Such a plan would better enable implementation and integration prioritization and capital planning.

Recommendation #17: Eligibility for Other-than-Honorable Service

“Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.”

VA finds this recommendation neither feasible nor advisable.

The Commission’s own estimates indicate this change would cost \$864 million in FY 2019, increasing to \$1.2 billion in FY 2033. This recommendation therefore appears to contemplate health care for anyone with an other-than-honorable discharge. While VA agrees with the principle of serving this population of Veterans, the cost of doing so makes the recommendation not feasible at this time.

Many Servicemembers with other-than-honorable discharges qualify for health care for service-connected conditions and other benefits under existing authorities. VA will continue to serve this population. VA is also drafting proposed regulations which will update and clarify 38 C.F.R. §§ 3.12 and 17.34 to improve processes and procedures relating to

character of discharge determinations and expand tentative health care eligibility for certain former Servicemembers.

These changes will address many of the concerns raised by the Commission. For example, the rules will provide improved guidance about the consideration of mitigating factors such as extended overseas deployments, mental health conditions, and other extenuating circumstances. Also, VBA has, within the past year, updated its manual to streamline its other-than-honorable adjudicative procedures to expedite health care eligibility determinations and improve the Veteran experience by shortening the wait time.

Recommendation #18: Expert Advisory Body for Defining Eligibility and Benefits

“Establish an expert body to develop recommendations for VA care eligibility and benefits design.”

VA finds this recommendation feasible and advisable.

Substantial changes in the delivery of health care have occurred since Congress last comprehensively examined eligibility for VHA care through passage of Public Law 104-262, *Veterans’ Health Care Eligibility Reform Act of 1996*, and taking a close look at eligibility criteria in light of current (and projected future) resources and demand makes sense in the context of VA’s ongoing efforts to reshape the future of VA health care. VA will work with the President, Congress, Veterans Service Organizations, and other stakeholders to determine the path forward in the tasking of an expert body to examine and, as appropriate, develop recommendations for changes in eligibility for VA health care benefits.

Recommendation 18 also includes a separate and distinct recommendation for VA to “revise VA regulations to provide that service-connected-disabled Veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.” While VA supports the objective, VA already has regulations (38 C.F.R. 17.49) and policy in place giving priority in scheduling to service-connected Veterans and believes these meet and fulfill the Commission’s intent.

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Deadlines and Milestone Dates from Mission based on 6/6/18 Signing			
Date	Page	Section	Description
6/5/2018	8	Sec. 101 (a) "1703(d)" Community Care Program	Last day that a veteran may grandfathered into the new program based on prior CHOICE 40-mile eligibility
6/6/2020	9	Sec. 101(a) "1703(d)" Community Care Program	Date to which a veteran who was prior CHOICE 40-mile eligible, but does not reside in one of the five low population states, may be grandfathered into the new program
6/5/2018	18	Sec. 101(a) "1703(h)" Community Care Program	Any new contract shall recognize and accept, on an interim basis, the credentials and qualifications of health care providers who are authorized to furnish hospital care and medical services to veterans under the CHOICE program as of this date
12/6/2019	22	Sec. 101(a) "1703(m)" Community Care Program	540 days after enactment and yearly thereafter, VA shall submit to Congress a review of the types and frequency of care sought under conditions in which care is required to be furnished through community providers
12/6/2019	25	Sec. 101(a) "1703(m)" Community Care Program	540 days after enactment and yearly thereafter, VA shall submit a report to Congress on the information gathered via the monitoring of hospital care, medical services, and extended care services furnished through community providers
6/6/2019	26	Sec. 101(b) Community Care Program	Effective date for the amended §1703 is the latter of the date that is 30 days after the final report required by PL 113-146 or the date on which SecVA promulgates regulations
6/6/2019	27	Sec. 101(c) Community Care Program	VA shall promulgate regulations to carry out §1703
10/6/2018	27	Sec. 101(c) Community Care program	First update on progress of establishing §1703 regulations
10/6/2018	43	Sec. 104(a) "1703B(d)" Access Standards	First update on progress towards developing access standards
3/6/2019	43	Sec. 104(a) "1703B(d)" Access Standards	Report detailing access standards submitted to Congress
12/6/2020	43	Sec. 104(a) "1703B(d)" Access Standards	Report to Congress on implementation of and compliance with access standards
6/6/2022	44	Sec. 104(a) "1703B(d)" Access Standards	Not later than 3 years after establishing access standards, requires a review and report to Congress on any findings regarding or needed modifications of the standards. Subsequent reports required no less than once every 3 years thereafter
10/6/2018	47	Sec. 104(a) "1703C(a)" Standards for Quality	First update on progress towards developing standards for quality
3/6/2019	47	Sec. 104(a) "1703C(a)" Standards for Quality	Report detailing standards for quality submitted to Congress
3/6/2020	48	Sec. 104(a) "1703C(b)" Standards for Quality	Publish the quality rating of facilities on CMS Hospital Compare website
3/6/2021	48	Sec. 104(a) "1703C(a)" Standards for Quality	Consider and solicit public comment on potential changes to measures used in standards
6/6/2019	51	Sec. 105(a) "1725A(g)" Walk-In Care	VA shall promulgate regulations to carry out this §1725A
6/5/2018	54	Sec. 106(a) "7330C(a)" Quadrennial VHA Review	VA shall submit to Congress the market area assessments completed by or being performed on the day before the date of enactment
6/6/2019	55	Sec. 106(a) "7330C(b)" Strategic Plan	VA shall submit to Congress a strategic plan to meet health care demand one year after enactment, and every four years thereafter
6/6/2019	60	Sec. 108(a) Prevention of certain health care providers from providing services	VA shall deny or revoke the eligibility of health care providers to provide non-VA care if the provider violated VA policy for safe care or the requirements of a medical license
6/6/2020	61	Sec. 108(d) Prevention of certain health care providers from providing services	Comptroller General shall submit a report on the implementation
As needed	63	Sec. 109(a) "1706A(a)" Remediation of Medical Service Lines	Not later than 30 days after determining that a medical service line of VA does not comply with the standards for quality established by VA, VA shall submit to Congress a report assessing what happened and a plan for remediation
As needed	64	Sec. 109(a) "1706A(c)" Remediation of Medical Service Lines	Following any submission of an assessment required by a medical service line not complying with the standards for quality, VA shall submit to Congress an interim progress report within 180 days
As needed	65	Sec. 109(a) "1706A(d)" Remediation of Medical Service Lines	Once each year a report will be submitted to Congress on all assessments required by a medical service line not complying with the standards for quality from the preceeding year
6/6/2019	68	Sec. 111(a) "1703(d)(3)" Prompt Payment	VA shall report annually to Congress on payment of overdue claims aggregated by paper and electronic
9/6/2018	71	Sec. 111(a) "1703(h)" Prompt Payment	VA shall submit to Congress a report on the feasibility and advisability of adopting funding mechanism similar to other Federal agencies to allow a contracted entity to distribute federal government funds
Annually	80	Sec. 121(d) Education Program	Once each year VA shall submit a report to Congress on the findings of the evaluation on the effectiveness of the education program for veterans on health care options

Annually	81	Sec. 122(b) Training Program	Once each year VA shall submit a report to Congress on the findings of the evaluation on the effectiveness of the training program for the administration of non-department health care programs
Annually	86	Sec. 131(c)(3) Safe Opioid Practices	Once each year VA shall submit a report to Congress evaluating the compliance of covered health care providers with safe opioid prescribing practices
6/6/2019	90	Sec. 133(c) Competency Standards	VA shall develop and implement competency standards for non-VA health care providers in clinical areas where VA has special expertise
45 days prior to budgetary impact	93	Sec. 141. Supplemental Appropriations	Shall submit to Congress justification for any supplemental appropriations requirement outside of the budget process no later than 45 days prior to budgetary impact on program or service
3/1/2019	94	Sec. 142 Choice Fund Flexibility	Amounts remaining in the Choice fund may be used for other non-Department provider programs
6/6/2019	95	Sec. 143 Sunset of CHOICE	VA may not use the authority under CHOICE to furnish care after this date
one year after provision of services or regulations	99	Sec. 151 (c) Telemedicine	VA shall submit a report to Congress on the effectiveness of the use of telemedicine
	104	Sec. 152(a) "1703E(d)" Center for Innovation	Pilot Programs under this section shall terminate no later than 5 years after commencement of the program
12/6/2019	109	Sec. 152(a) "1703E(g)(3)" Center for Innovation	Subsection (f) waiver provision does not apply unless VA submits the first proposal for a pilot program not later than 18 months after enactment
Upon VA certification of implementation of the IT System	114	Sec. 161(a) Expansion of Caregiver Program	Upon VA certification of IT system to Congress, eligibility will expand to those who served on or before May 7, 1975 and on or after September 11, 2001 30 days after the date on which VA submits the certification to Congress, VA must publish the date specified in the Federal Register
2 years after VA certification of implementation of the IT System	115	Sec. 161(a) Expansion of Caregiver Program	2 years after certification submission, eligibility will be open to those who served after May 7, 1975 and before September 11, 2001.
9/4/2018	122	Sec. 162(d) Implementation of Caregiver IT system	Not later than 90 days after enactment, VA shall submit a report assessing the needs of the Caregiver program, the implementation of the IT system, and any changes needed
10/1/2018	120	Sec. 162(a) Implementation of Caregiver IT System	Not later than this date, VA shall implement an information technology system that fully supports the program and allows for data assessment and comprehensive monitoring
10/1/2019	124	Sec. 162(d) Implementation of Caregiver IT System	VA shall submit to Congress a report on the implementation, assessment, and monitoring of the Caregiver IT system
3/29/2019	121	Sec. 162(b) Implementation of Caregiver IT system	Not later than 180 days after implementing the IT system, VA shall use data to conduct an assessment of key program aspects
5/31/2021	127	Sec. 202(c) The Commission	The President shall transmit to Senate the nominations for appointment to the Commission not later than this date
2/1/2021	134	Sec. 203(a) Procedure for Making Recommendations	Not later than this date, VA shall publish in the Federal Register and transmit to Congress its criteria proposed to be used in making recommendations regarding the modernization or realignment of facilities of VHA The public will have at least 90 days to comment
5/31/2021	135	Sec. 203(a) Procedure for Making Recommendations	VA shall publish the final criteria and transmit them to Congress
1/31/2022	135	Sec. 203(b) Procedure for Making Recommendations	VA shall publish in the Federal Register and transmit to Congress and the Commission a report detailing the recommendations for realignment and modernization.
1/31/2023	143	Sec. 203(c) Procedure for Making Recommendations	The Commission shall transmit to the President a report containing the findings and conclusions based on review and analysis of the recommendations made by VA
2/15/2023	145	Sec. 203(d) Procedure for Making Recommendations	Not later than this date, the President shall transmit to the Commission and Congress a report containing the President's approval or disapproval of the Commission's recommendations
3/1/2023	145	Sec. 203(d) Procedure for Making Recommendations	If the President disapproves the recommendations of the Commission, in whole or in part, the President shall transmit to the Commission and Congress the reasons for that disapproval
3/15/2023	146	Sec. 203(d) Procedure for Making Recommendations	After consideration of the disapproval, the Commission shall transmit a report to the President with review and analysis of the disapproval and recommendations for modernization and realignment
3/30/2023	146	Sec. 203(b) Procedure for Making Recommendations	If the President fails to transmit to Congress an approval and certification described above by this date, the process for facility modernization and realignment shall be terminated
	147	Sec. 204(a) Actions Regarding Infrastructure	No later than 3 years after the President transmits the recommendation report to Congress, VA shall begin to implement recommendations
	147	Sec. 204(b) Actions Regarding Infrastructure	Secretary may not implement any recommendations if a joint resolution of disapproval is enacted within 45 days of report transmittal

	163	Sec. 207(e) AIR Account	No later than 60 days after the closure of the account VA shall submit to Congress a report of the funds credited to/expended from the account and any remaning funds in the account
9/30/2024	175	Sec. 211 Training of Construction Personnel	VA shall implement a covered training curriculum and covered certification program for members of occupational series related to construction or facilities management and contracting personnel in those specialties
12/6/2018	178	Sec. 213(a) Assessment of VA Health Care in the Pacific Territories	VA shall submit a report to Congress regarding health care furnished to veterans in the Pacific territories
6/6/2019	182	Sec. 302(a) Increase in Maximum Amount allowed under Education Debt Reduction Program	VA shall conduct a study on the demand for EDRP and report to Congress on that study's findings
	194	Sec. 304(b) Veterans Healing Veterans Medical Access and Scholarship Program	To be eligible, a veteran has to have been discharged from the Armed Forces not more than 10 years before the date of application for the Cals of 2019 to a covered medical school
12/6/2019	200	Sec. 401(a) Development of Criteria	VA shall develop criteria for the designation of certain medical facilities of the VA as underserved
6/6/2019	202	Sec. 401(a) Development of Criteria	Not later than one year after enactment and yearly thereafter, VA shall submit to Congress a plan to address the problem of underserved facilities
6/6/2019	203	Sec. 402(d) Pilot Program to Furnish Mobile Deployment Teams to Underserved Facilities	VA shall submit to Congress a report on the implementation of the pilot program
6/6/2021	203	Sec. 402(d) Pilot Program to Furnish Mobile Deployment Teams to Underserved Facilities	Upon the termination of the pilot program, VA shall submit a final report to Congress with recommendations on the feasibility and advisability of extending/expanding the program and making it permanent
6/6/2019	208	Sec. 403(c) Pilot Program on GME	One year after enactment, and yearly thereafter until termination of the pilot program, VA shall submit a report on implementation to Congress
8/7/2024	211	Sec. 403(d) Pilot Program on GME	Termination of the pilot program
1/8/2019	211	Sec. 501(a)"726(a)" Annual Report on Performance Awards and Bonuses	Not later than 100 days after the end of each fiscal year, VA shall submit to Congress a report that contains a description of all performance awards or bonuses awarded to high-level employees
7/6/2018	215	Sec. 502(b) Podiatrists in VA	The amendmentswith respect to pay grade shall apply to a pay period on or after 30 days after enactment
9/6/2018	216	Sec. 504(c) Authorization of Certain Major Medical Facility Projects of VA	VA shall submit to Congress information regarding expenditures, budgeting, justification of expenditures, and any agreements between VA and non-VA Federal entities as part of the Livermore CA realignment
9/6/2018	217	Sec. 505(a) VA Personnel Transparency	VA shall make publicly available on va.gov a number of metrics pertaining to VA employment. The information shall be updated quarterly
Annually	219	Sec. 505(b) VA Personnel Transparency	VA shall submit annually a report on steps taken to achieve full staffing
5/31/2019	220	Sec. 506(b) Program Peer Specialists in Patient Aligned Care Team Settings	VA shall establish the program at not fewer than 15 medical centers
5/31/2020	220	Sec. 506(b) Program Peer Specialists in Patient Aligned Care Team Settings	VA shall establish the program at not fewer than 30 medical centers
12/6/2018	221	Sec. 506(f) Program Peer Specialists in Patient Aligned Care Team Settings	Not later than 180 days after enactment, and every 180 days until VA determines the program is being carried out at the last location, VA shall submit to Congress a report on the program
	222	Sec. 506(f) Program Peer Specialists in Patient Aligned Care Team Settings	Not later than 180 days after the program is carried out in the last location VA, shall report to Congress on the feasibility and advisability of expanding the program
	224	Sec. 507(d) Medical Scribe Pilot	No later than 180 days after commencement of the pilot and every 180 days thereafter, Va shall report to Congress the status and effects of the pilot
	225	Sec. 507(d) Medical Scribe Pilot	Not later than 90 days after termination of the pilot GAO shall submit to Congress a report on the pilot program

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VA Directives Ideas Draft

(Goal – Improve VA Operations and the Culture)

VHA Tiger Teams – establishment and charter

- MISSION Act Implementation
- Commission on Care Recommendations Implementation
- Reengineer and Modernization of health care delivery at the facilities

VBA Tiger Teams – establishment and charter

- Disability and Compensation Claims and Appeals – process and implementation of legislation

Academic Affiliations – reorganization in VHA to report directly to PDUSH. This is a congressionally mandated mission. Possibly advisory committee

Office of Research - reorganization in VHA to report directly to PDUSH. This is a congressionally mandated mission. Development of private/public partnerships. Possibly advisory committee.

VHA VA Voluntary Service Office – direct to recruit more clinicians, IT expertise and private sector partnerships

Set up a Fraud Waste and Abuse Commission in accordance with POTUS campaign promise.

HR Reforms and OAWP – see commission on care recommendations

- Whistleblowers not fired if legitimate. Supervisor held accountable if target legitimate whistleblower
- New Bonus system based on performance outcomes and teams
- Hiring outside talent – speed and direct hire authority

New Employee Recognition policy -local and national quarterly awards program.

Winners get lunch with SECVA

New Veterans Customer Service Survey. What do veterans want and need from the VA.

Study/FACA – World Class Best Practices that can be applied to VA. This would cover all major areas – VHA, VBA, NCA, OIT. Recommendation on implementation.

Public/Private Partnership Competition. Get ideas and proposals for future public/private partnerships to improve VA operations and service to Veterans.

Transparency – have all administrations and staff offices identify what should be released to the public and posted on-line

Audit of VA fiscal spending, contracts and funds put off the books. Potential to stop significant FWA and recapture funds that can be repurposed. Can model like DoD audit.

Governance

- Reconstitute VA senior management and OIT governance process
- VHA – develop governance based on Commission on Care recommendation. Look at redoing the existing SMAG.

Clinical care staffing shortages- Do clinical contract support like is currently done with the CBOC to quickly fill clinical staffing gaps at the VAMCs or CBOCs.

Reestablish VA Learning University, its Board of Directors, steering committee and funding mechanism for department wide training. All existing training functions in the administrations and staff offices would have a dotted line to VALU.

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**Department of Veterans Affairs
Washington, DC 20420**

**VA DIRECTIVE 0214
August 11, 2014**

DEPARTMENT OF VETERANS AFFAIRS GOVERNANCE STRUCTURE

1. **REASON FOR ISSUE.** To prescribe policy for the Department of Veterans Affairs (VA) governance structure.
2. **SUMMARY OF CONTENTS.** This directive establishes the VA governance structure, and sets forth related policies, roles and responsibilities.
3. **RESPONSIBLE OFFICE.** The Office of Policy and Planning (008) is responsible for the contents in this Directive.
4. **RELATED HANDBOOK.** None.
5. **RESCISSIONS.** None

CERTIFIED BY:

/s/
Stephen W. Warren
Executive in Charge and
Chief Information Officer
Office of Information and Technology

**BY DIRECTION OF THE SECRETARY
OF VETERANS AFFAIRS:**

/s/
Robert D. Snyder
Acting Assistant Secretary
Office of Policy and Planning

Distribution: Electronic Only

August 11, 2014

VA DIRECTIVE 0214

DEPARTMENT OF VETERANS AFFAIRS GOVERNANCE STRUCTURE

1. PURPOSE. This Directive establishes VA's governance structure, and related policies, roles, and responsibilities.

2. POLICY.

a. General. Governance is the process by which VA Senior Leadership makes decisions, provides strategic direction, and maintains accountability in a transparent and collaborative manner. This process enables informed decision-making based on current strategic objectives, VA's risk appetite, and responsible resource allocation.

(1) VA's principal governance bodies are the VA Executive Board (VAEB) and Senior Review Group (SRG). These bodies may formally charter other standing and ad-hoc cross-Department governance bodies, as needed. All VA governance bodies are intended to enable efficient decision-making and to promote the timely sharing of information on matters of mutual interest between and among VA's Administrations and Staff Offices.

(2) Through its role as the principal advisor to the Secretary on policy and strategy, the Office of Policy and Planning (OPP) will serve as the secretariat for the VAEB and SRG. The secretariat will establish standard operating procedures, request agenda items for consideration (see Appendix A for the agenda setting process), and prepare and transmit meeting materials.

b. VA Executive Board (VAEB).

(1) *Role of the VAEB.* The VAEB is the final decision making body for VA. The VAEB reviews and evaluates data and information to determine VA's strategic direction, oversee the Department's Planning, Programming, Budgeting and Execution (PPBE) process, and other activities by which it serves as the senior decision-making body for Department-wide decisions. The VAEB approves the Department's Strategic Plan, Agency Priority Goals, Multi-Year Program, Budget, Annual Performance Plan, and Annual Performance Accountability Report. The VAEB serves as the Department's Risk Governance Board. The VAEB also addresses any issues that are elevated from the Monthly Performance Review (MPR), Operational Management Review (OMR), Joint Executive Council (JEC) or Senior Review Group (SRG). As needed, the VAEB may direct the creation of additional Department governance bodies.

(2) *VAEB Membership.* The VAEB is chaired by the Secretary of VA (SECVA). The VAEB consists of: the Deputy Secretary of VA (DEPSEC); the Chief of Staff of VA (COSVA); the Under Secretaries for Health, Benefits and Memorial Affairs; all Assistant Secretaries and equivalents; the General Counsel; and the Chairman of the Board of Veterans Appeals. Members of the VAEB serve as senior advisors to the SECVA. At the request of the SECVA, other representatives (e.g. OSVA's Special Program Directors) may attend the meetings.

VA DIRECTIVE 0214**August 11, 2014****c. Senior Review Group (SRG).**

(1) *Role of the SRG.* The SRG ensures VAEB decisions and direction are implemented across the Department; serves as the senior decision-making body for operational and administrative matters that do not require a decision by the VAEB; and acts as the de-facto steering committee for standing and ad-hoc cross-Department governance bodies created by the VAEB. The SRG also serves as a forum for reviewing proposed agenda items for VAEB and SRG meetings.

(2) *Membership.* The SRG is chaired by the COSVA. The SRG consists of: the VA Deputy Chief of Staff ; the Principal Deputy Under Secretaries for Health, Benefits, and Memorial Affairs; all Principal Deputy Assistant Secretaries and equivalents; the Principal Deputy General Counsel; the Vice Chairman for the Board of Veterans' Appeals, OSVA's Special Program Directors (Center for Women Veterans (CWV), Center for Minority Veterans (CMV), Center for Faith Based and Neighborhood Partnerships (CFBNP), Office of Survivors Assistance (OSA), and Office of Small and Disadvantaged Business Utilization (OSDBU)). SRG members serve as advisors to the Chair. At the request of the COSVA, other representatives may attend the meetings.

d. Other cross-Department governance bodies. Standing and ad hoc cross-Department governance bodies are established at the direction of the SECVA, DEPSEC or COSVA. Reporting procedures are assigned by the VAEB and/or SRG.

(1) *Standing cross-Department governance bodies.* Standing cross-Department governance bodies include those bodies that are statutorily required and/or created at the direction of the VAEB, chaired by a Deputy Assistant Secretary or higher, and will be comprised of Senior Executive Service (SES) representatives from across the Department. These bodies meet on a recurring basis to provide input to strategic direction, ensure strategic objectives are achieved, manage risk, manage resources, or manage organizational design and reporting structures. See Appendix B for a list of current standing cross-department governance bodies.

Standing cross-Department governance bodies are required to develop a charter, which includes purpose and function, membership, roles and responsibilities of members, and a process for reporting status updates to VA Senior Leadership. The chair of each body is responsible for ensuring a charter is developed and approved, and the governance body is included in the VA Functional Organization Manual (FOM).

(2) *Ad hoc cross-Department governance bodies.* Ad hoc cross-Department governance bodies are created at the direction of the SECVA, DEPSEC, and COSVA, and consist of representatives from across the Department selected to address a short-term issue, challenge, or opportunity. These bodies accomplish a specific set of activities within a specified timeframe.

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Ad hoc cross-Department governance bodies are required to develop a work plan, which includes purpose, scope and objectives, projected timeframe of activities, milestones and deliverables, resources required, and a process for reporting status updates to the SRG.

3. RESPONSIBILITIES.

a. Under Secretaries, Assistant Secretaries and Equivalents. Under Secretaries, Assistant Secretaries, and Equivalents will:

- (1) Ensure attendance and participation in VA governance bodies in which their organization is a member.
- (2) Establish internal processes to elevate status, issues, or decisions to the SRG and/or VAEB, and to respond to requests for agenda items.
- (3) If applicable, ensure standing cross-Department governance bodies, which they chair (or co-chair), are formally chartered, have processes in place to efficiently and effectively report status, include members that have decision making authority for their organizations, and have a mechanism to note the chairmanship of the governance bodies in the VA FOM.
- (4) If applicable, ensure ad hoc cross-Department governance bodies, for which they are responsible to chair (or co-chair), have a work plan, and processes are in place to efficiently and effectively report status.
- (5) Elevate issues for decision to the VAEB and SRG as needed.

b. Office of Policy and Planning (OPP). OPP will:

- (1) Serve as the secretariat for the VAEB and SRG.
- (2) Establish standard operating procedures for VAEB and SRG.
- (3) Prepare and transmit meeting materials for the VAEB and SRG.

4. REFERENCES

- a.** 38 U.S.C. Chapter 5
- b.** VA Directive 0211, Functional Organization Manual Management

VA DIRECTIVE 0214**August 11, 2014****5. DEFINITIONS.**

a. Ad hoc cross-Department governance body. A body created at the direction of the SECVA, DEPSEC, COSVA, consisting of representatives from across the Administrations and Staff Offices, and whose purpose is to accomplish a specific set of activities within a specified timeframe.

b. Administration. A generic term used to identify one of the three major VA operational elements:

- (1) Veterans Health Administration (VHA)
- (2) Veterans Benefits Administration (VBA)
- (3) National Cemetery Administration (NCA)

When VHA, VBA and NCA are referred to as a group, the term “Administrations” may be used.

c. Department. A generic reference to the entire Department of Veterans Affairs which includes VA Central Office and all field facilities.

d. Staff Office. A generic term used to identify one of the offices included under VA Central Office. This does not refer to VHA, VBA, and NCA, nor does it refer to medical facilities, regional offices or cemeteries.

e. Standing cross-Department governance body. A body created at the direction of the VAEB, chaired by a Deputy Assistant Secretary or higher, comprised of SES representatives from across the Administrations and Staff Offices that meets on a recurring basis, and whose purpose is to provide strategic direction, ensure strategic objectives are achieved, manage risk, manage resources, or manage organizational design and reporting structures.

August 11, 2014

**VA DIRECTIVE 0214
Appendix A**

AGENDA SETTING PROCEDURES

Each quarter, OPP will:

1. Issue a formal agenda item call letter to VAEB and SRG members and the chairs of standing and ad-hoc cross-Department governance bodies.
2. Consolidate agenda items into a proposed three-month schedule and present the document to the SRG for review.
3. Present the proposed three-month schedule to the Chairs of the VAEB and SRG, or their designees, for approval.
4. Disseminate the approved three-month schedule to the VAEB, SRG, and chairs of standing and ad-hoc cross-Department governance bodies.

*Given changing priorities and emergent issues that may arise during the year, the Chairs of the VAEB and SRG, or their designees, will consider adding items to the agenda outside of the formal process on a case-by-case basis. VAEB and SRG members who want to add an agenda item outside of the formal process should contact OPP for further guidance.

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VA Reform Agenda – Five Ways to Move Forward

The 2015 Independent assessment of VHA performed in advance of the Commission on Care, identified four integrated cornerstones to fixing VHA, these cornerstones can also be used to reform and modernize all of VA. The cornerstone includes: Governance, Operations, Data and Tools, and Leadership. See page xviii of the Independent Assessment, https://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf

Although there are many initiatives and tasks that need to get done, below are five key initiatives and tasks that can provide significant forward momentum and are important to moving ahead with the needed VA reforms and modernization. It is crucial going forward to create a unified leadership team, with a roadmap for both short term tactical and long term strategic success.

1. **POTUS VA healthcare campaign promise** “Mr. Trump will ensure every veteran has the choice to seek care at the VA or at a private service provider of their own choice. Under a Trump Administration, no veteran will die waiting for service.”

Description: The MISSION Act was an intermediate step to achieving POTUS promise for full Choice. Commission on Care recommendation #1 provides a roadmap to fulfill that promise both operationally and fiscally (attached). However, it must be developed and tested out before it can be implemented. The Center for Innovation was created as the vehicle to test out full choice using pilots. Full choice also means fixed up and modern VA healthcare delivery and facilities. A vision and comprehensive plan needs to be developed to achieve this as a companion to the community care plan.

Action Items:

MISSION Act Implementation: Create a cross functional Tiger Team lead by Dr. Stone and Larry Connell with representation from VHA, OCLA, OPIA, OIT, Contracting. Develop full project plans with Gantt charts. Weekly status briefing to SECVA at senior management meeting.

Develop VHA Modernization and Healthcare Delivery Vision (VA Healthcare System)/Strategic and Project Plan: Incorporate/modify Commission on Care report/recommendations. Set up VHA tiger team with staff and contractor expertise. TRICARE Integration plan WH/JEC. Restart with WH the TRICARE Integration PCC to identify synergies, efficiencies and expertise that can be leveraged to improve both VA and DoD healthcare operations and be cost efficient.

Bring in needed expertise to VHA through DoD/HHS details, industry expertise (MITRE can assist).

Expand the use of contract providers such as VALOR for healthcare delivery shortages and quick relief for CBOCs/Hospitals. Currently 15% of CBOCs are contracted out and are under the VA name.

Center for Innovation: Set up the Center and develop the pilot(s) required to test out and fulfill POTUS Choice promise – using Commission on Care Recommendation 1 as an initial roadmap.

2. **Commission on Care Report Recommendations Implementation**

Description: In 2016 the Commission finished its report and made 18 recommendations. President Obama signed off on 15 of the 18 recommendations as feasible and advisable, <https://obamawhitehouse.archives.gov/the-press-office/2016/09/01/letter-president-report-va-commission-care>. Just like an EO, VA is still required to go forward with those recommendations. To date VA has taken very little action. Last year the Commissioners met with SECVA and staff to review progress, very little had taken place. VHA does have a tracking spreadsheet. Implementation of these recommendations are key to modernizing and improving VHA healthcare delivery and overall operations.

Action Items:

- Bring back key Commission members for one day to meet with SECVA and staff to review progress and have a working session on implementation
- VHA staff update tracking spreadsheet on progress
- Review the three recommendations not signed off by President Obama to see if they are feasible and advisable.
- Have VHA create implementation and project plans with Gantt chart.
- Set up VHA tiger team for implementation
- Report on status and results to WH and Congress

3. **Modernize and Restore VA Department-wide business operations and governance**

Description: Over the last eight years VA governance and business operations have fallen into disrepair and are extremely outdated and inefficient. This is most pronounced in the areas of OIT, HR and Training, Acquisition and Contracting, Governance. In addition, the accountability legislation has not been implemented fully or correctly due to lack of support and interference from the previous SECVA and his COS. Restoring, modernizing and properly operating these functions are critical for VA reform and success.

Action Items:

Set up tiger teams to restore and modernize the areas below. Bring in outside expertise from government and the private sector to develop the plans and oversee implementation with the responsible office.

HR operations needs total restructure: recruitment, hiring, retention, performance management, education and training

Restore and Rebuild VA Learning University and its governance and funding mechanisms. This was the Department-wide education and training and was very success until it was mismanaged, and then disbanded during the previous administration. New strategic plan will need to be developed. Attached is the old strategic plan.

Accountability Legislation Implementation – finish complying with legislation, fully staff OAWP and develop all the processes and procedure required.

Governance – SECVA McDonald stopped using the established Governance process and organization. SECVA Shulkin did not use it as well. This resulted in chaotic and poorly vetted decisions by SECVA and senior staff. This needs to be restored and updated to fit

the needs of VA today. Attached is the current governance structure that is not being used.

Contracting: Processes, procedures are inefficient, outdated and slow. This area needs a total overhaul and is negatively impacting MISSION Act implementation.

Business Transformation office residing in OEI – reporting to DEPSEC/COS: This new office would manage the tiger teams, process and project manage the overall VA reform and modernization efforts. Led by political, it would be a team of career and contract experts. It would work hand in hand with the business owners who would be accountable for results. A scorecard would grade the efforts and reported out quarterly to SECVA. Progress would be briefed to SECVA and the leadership team monthly.

4. **VA Modernization and Reform Commission** – see attached one pager

Description: The VA has numerous reform and modernization initiatives that have stagnated due to lack of focus and expertise. The private sector has expertise the VA needs, but VA has lacked a structure to utilize the expertise. Organizations such as Apple, Mayo Clinic, Cleveland Clinic, Kaiser Permanente among other have offered their expertise free of charge. Having a new and broad Commission that follows FACA, can be the vehicle to properly bring in and utilize private sector talent. WH DPC has been briefed and supports this concept.

Purpose: Provide VA with the best talent and expertise in the country to advise and assist in reforming and modernizing VA to ensure Veterans are provided world class service with all benefits among the three administrations.

Authorizing Directive: WH would create a directive from POTUS requiring VA to setup and manage the Commission and report back to POTUS through WH DPC on the results.

Structure: The commission would be in accordance with FACA, department-wide and divided into four subcommittees. Full commission meetings would be public, subcommittees would be private.

VHA

VBA

NCA

OIT/EHR

Action Items

VA meet with WH DPC and work together to develop the draft directive that would then go through WH Staff Sec for routing and approval.

5. **Senior Management 1 Day Retreat**– Political and Career (Sharing the vision, building the team, prioritizing operations and identifying quick wins)

Description: Each year there is normally around April there is a Senior Management retreat that bring together all the SES from around the country. Due to this year's unique circumstances, the retreat has not happened, and senior staff are unclear on the vision and direction of the new SECVA and his leadership team, his priorities and vision. This confusion

and lack of clarity is hampering operational effectiveness and morale. Before a department-wide senior management retreat can happen, it is important for the VACO senior leadership team to first meet. Recommend SECVA and his leadership VACO team have a 1-day retreat as soon as possible to set expectations, vision, priorities, process and operation procedures and tempo. After that meeting, then have the larger department-wide SES meeting so that all VA senior management are on the same page.

Action Items:

Develop a one-day senior management off-site retreat. Some of the topic areas include but are not limited to the following:

- Senior management team expectations: communication, performance, implementation, meetings, accountability, culture, work processes between SECVA office, three administrations and staff offices
- New VA Directives: Identification and Implementation – use to improve operations, governance, culture and morale, see attached list
- POTUS 10 Veterans Campaign Promises Implementation: These need to be completed as soon as possible. Review using tracking spreadsheet, which can be obtained from VA staff or WH DPC. Press and detractors will bring this up at Veterans Day and POTUS two-year anniversary.
- Review of business operations: governance, processes, procedures, Hill, press, decision making, WH, senior management meetings, stakeholders, interaction between SECVA office, staff offices and three administrations
- Develop an outline of what the follow up department-wide SES meeting should focus on, topic and outcomes.

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Proposed VA Reform and Modernization Commission

Purpose: Provide VA with the best talent and expertise in the country to advise and assist in reforming and modernizing VA to ensure Veterans are provided world class service and benefits.

Authorizing Directive: This would be a directive from POTUS requiring VA to setup and manage the Commission

Structure: The commission would be in accordance with FACA, department-wide and divided into four subcommittees. Full commission meetings would be public, subcommittees would be private.

VHA

VBA

NCA

OIT/EHR

Example Subcommittee Work

VHA: Choice legislation implementation, Eligibility and Benefit reform, Commission on Care recommendations, Facility modernization

VBA: Disability and Compensation reform

OIT/EHR: EHR implementation

Membership: All members appointed to the Commission would be required to fill specific qualifications and expertise needs

Experts in a variety of fields and industries, both private and government

Experts from the five medical centers

Stakeholders: VSOs and Congress

Benefits/Advantages:

Focus and direction that will accelerate reforming and modernizing VA

Provides faster movement and progress on POTUS commitment to veterans and campaign promises

Good public relations – focuses VSOs, Congress, Veterans and public on positive direction that VA is moving in

Provides avenue and mechanism to bring in experts and stakeholders

Ability to formally engage the five medical centers that have informally advising VA

Quarter Reporting: Full Commission and subcommittees will report out their progress and recommendation to POTUS, through SECVA and DPC.

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Department of Veteran Affairs

Education and Training Strategic Plan

July 2003



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Executive Summary

While the Department of Veterans Affairs (VA) provides substantial Administration-specific technical training in support of the Nations veterans, there has been limited coordination throughout the Department to ensure that all education and training efforts are aligned, consistent, and effective. With the advent of the Chief Human Capital Officers Act of 2002, new emphasis has been placed across the Federal government on workforce development. To address the legislation and continue to meet its mission, the VA has created this Department-wide Education and Training Strategic Plan (ETP) to communicate the overall vision and strategy while maintaining a clear alignment with the Department's mission and strategic plan.¹ The ETP is intended to institutionalize learning formally across the Department and encourage a culture of continuous learning for its employees.

To accomplish the goals of this effort as quickly as possible, a qualitative rather than a quantitative approach to data collection and analysis was used. Analyses and conclusions were drawn from data recently acquired from interviews, focus groups, and surveys, as well as information previously collected through prior initiatives. Based on strategic issues identified during data collection, corresponding strategic goals were then developed to help address the issues (summarized in the table below):

Strategic Issues	Strategic Goals
1. The Departmental focus on education and training requires more consistent support and funding.	1. Identify and assign a Departmental organization to ensure education and training is incorporated into budget, resourcing, planning, and performance measurement.
2. Effective planning for education and training programs needs to be strengthened and standardized throughout the Department.	2. Ensure education and training plans are developed and aligned with human capital plans at all organizational levels as a part of the VA strategic planning cycle.
3. VA does not have a clear line of responsibility and accountability for the implementation of a comprehensive Department-wide education and training plan.	3. Define and assign roles, responsibilities, and an accountability structure clearly for VA education and training.
4. Critical education and training gaps in leadership development and corporate career fields need to be addressed.	4. Enhance existing leadership development and cross-cutting career fields training programs to meet VA workforce needs.
5. Department-wide communications regarding VA education and training programs need to be more effective.	5. Develop and implement a communication and marketing plan to create a heightened awareness by employees at all levels on the full scope of learning opportunities and responsibilities.

¹ An Enabling Goal from the VA Strategic Plan (2001-2006) notes the importance of creating "an environment that fosters the delivery of One VA world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources."



A “Strengths, Weaknesses, Opportunities, and Threats” or “SWOT” analysis was then conducted to help determine appropriate implementation tactics for achieving the goals identified by the Department-wide Education and Training Plan Working Group (Working Group) appointed by the Deputy Secretary to lead this initiative (summarized in the table below):

Strengths	Weaknesses
<ol style="list-style-type: none"> 1. Infrastructure for Distance Learning 2. Administration-specific Training 3. The High Performance Development Model (HPDM) 	<ol style="list-style-type: none"> 1. Lack of Departmental Focus on Education and Training 2. Lack of Department-wide Initiatives 3. Lack of Funding 4. Lack of Department-wide Learning Management System (LMS)
Opportunities	Threats
<ol style="list-style-type: none"> 1. Technology-Enabled Learning 2. Components of Leadership Development Training 3. Employee Orientation and Career Paths 4. Communications and Marketing Learning Opportunities 5. Leverage Department-wide Purchasing 6. Provide Clear Linkages to Human Capital Management 	<ol style="list-style-type: none"> 1. Placement of Education and Training Oversight 2. Insufficient or Poorly-Leveraged Resources 3. Lack of Performance-based Measures 4. Failure to Institutionalize and Champion Education and Training

To provide a path forward, the Working Group developed the following recommendations and suggested “next steps” for achieving ETP Goals:

1. Establish an Office of Employee Education and Training headed by a senior executive to serve as the focal point for education and training in support of VA strategic management of human capital. Among its responsibilities, this office will:
 - a. Be responsible and accountable for departmental education and training policy, planning, evaluation, and oversight;
 - b. Be responsible for managing the programs currently managed under the umbrella of VALU;
 - c. Be responsible for leading a governance structure for education and training issues of departmental significance (e.g., funding for VA-wide program needs, vetting proposals for department-level training programs, etc.);
 - d. Be responsible for filling identified, department-level operational gaps:
 1. Leadership and supervisory development training
 2. Training programs for VACO Staff Offices and cross-cutting career fields
 3. Other training with VA-wide applicability (e.g., customer service training, new employee orientation, etc.)



2. Institutionalize education and training planning as a component of VA's strategic planning and budgeting cycle to ensure adequacy of funding and alignment with Departmental strategic goals.
3. Complete the implementation of initiatives critical to the overall success of education and training within VA (recommended Office of Employee Education and Training should take a lead role) such as HPDM and implementing a Department-wide LMS.
4. Decide appropriate VA organizational alignment for the Office of Employee Education and Training.

Regardless of the direction chosen, several initiatives can be pursued immediately for positive change:

- Add the Chief Human Capital Officer (CHCO) to the VALU Board of Directors Executive Committee (helping ensure alignment with Human Capital Planning).
- Assign responsibility to an interim executive for implementing the strategies and supporting objectives outlined in the ETP.
- Prioritize initiatives and develop an implementation plan addressing high priority items.
- Expedite the acquisition of a Department-wide Learning Management System (LMS).
- Ensure the alignment between the ETP and ongoing education initiatives within the Department (e.g., e-Learning Strategy and Training Policy Revision).



1.0 Introduction

1.1 Purpose

The Department of Veterans Affairs (VA) is seeking to institutionalize learning across the entire organization. To achieve this goal, the VA has created this Department-wide Education and Training Strategic Plan (ETP) to communicate the overall vision and strategy within the Department. More specifically, the ETP:

- Sets near-term strategic direction and priorities for education and training, including career and leadership development and enhanced customer service;
- Aligns education and training initiatives with VA strategic goals;
- Helps to define the role and focus of the VA Learning University (VALU) in supporting the organization (specifically for FY2004-2007) while helping the organization to leverage existing assets more effectively;
- Establishes clear accountability for learning within the Department.

Currently, the way Federal Government manages its workforce is under significant transformation. With the advent of the Chief Human Capital Officers Act of 2002, new emphasis is being placed on workforce development, and the implementation of a culture of continuous learning. The ETP has been designed to respond to this charge while maintaining a clear alignment with the Department's mission and strategic plan.

In support of the Department's Enabling Goal and Objective E-1, the ETP will drive the needed change throughout VA to ensure that employee education and training programs will provide accessibility to the requisite knowledge and skills to ensure the delivery of world class service to the veterans and their families.²

To create this plan, VERTEX Solutions, Inc. (VERTEX) worked cooperatively with a Department-wide Education and Training Plan Working Group (Working Group), appointed by the Deputy Secretary to conduct a high-level assessment of the organization, validate previous efforts, and to identify emerging issues. This input was used to facilitate strategic planning sessions with Working Group participants to define the VA Education and Training Plan, the outcome of which is presented in this document.

1.2 Scope

The scope of this project was to facilitate a VA-wide Working Group to create an education and training strategic plan. Expected outcomes from this effort included:

- A definition of VA strategic education and training goals;

² The Enabling Goal is stated in the VA Strategic Plan (2001-2006) as "Create an environment that fosters the delivery of One VA world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources." Objective E-1 is defined as "Improve communications with veterans, employees, and stakeholders to share the Department's mission, goals, and results to increase awareness of benefits and services for veterans and their families."



- A high-level education and training strategy to support these goals including integration of Department-wide learning initiatives and resources;
- Desired outcomes and initial requirements for future training programs;
- Initial implementation tactics to include follow-on priorities, tasks, and milestones;
- The role of the VA Learning University (VALU) and its position within the organization;
- The defined relationship to Department human capital policies and plan.

1.3 Methodology

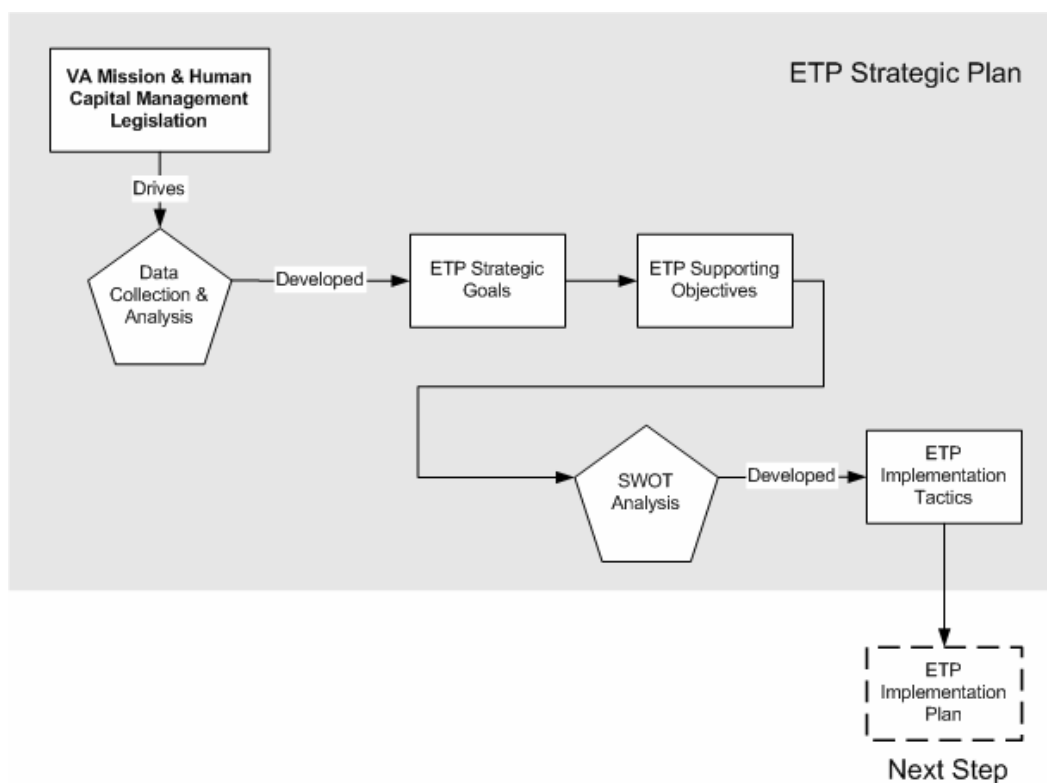


Figure 1 – ETP Methodology

To accomplish the goals of this effort as quickly as possible, VA and VERTEX agreed to use a qualitative rather than a quantitative approach to data collection and analysis. Rather than performing an exhaustive, quantitative data collection initiative Department-wide, analyses and conclusions were drawn from interviews, focus groups, surveys, and information previously collected through prior initiatives. More specifically, the data collection process included the following activities:

- Conducting a series of senior stakeholder interviews;
- Facilitating Department-wide focus groups with mid-level management;



- Developing a Department-wide, Web-based survey directed at a broader VA employee base; and
- Reviewing Government Furnished Information (GFI) for a more thorough understanding of existing processes and procedures.

The Web-based survey enabled the Working Group to gain a greater understanding of the perceived issues and attitudes toward education and training within the VA. The results of this phase were recorded in a Data Collection Report, and submitted to the VA for review and acceptance. Following submission of the report, VERTEX facilitated two, all day working sessions to develop the strategic vision, mission, core values, goals, high-level objectives, and concepts for a VA-wide education and training organization.

As illustrated in Figure 1 (page 5), and based on the strategic issues identified during data collection, corresponding strategic goals and supporting objectives (more detailed components of the goals) were developed to address the strategic issues. The goals and supporting objectives were then subjected to a “Strengths, Weaknesses, Opportunities, and Threats” or “SWOT” analysis to help determine appropriate implementation tactics for achieving the goals identified by the Working Group. These implementation tactics are provided in Section 5.0 – Recommendations and Next Steps (page20), and are intended to serve as the foundation for a formal implementation plan once the ETP is reviewed and approved by VA.



2.0 Strategic Issues

Based on an analysis of the data collected, five education and training strategic issues were identified. Based in part on the perceptions collected through the interviews, focus groups, and survey, these issues represent the basis for developing the ETP's strategic goals and objectives. These issues target the implementation of education and training as a Department-wide strategy.³

2.1 Departmental Focus

Strategic Issue 1: The Departmental focus on education and training requires more consistent support and funding.

Those participating in the assessment phase generally believe that education and training is important to accomplishing the Department mission. However, with the exception of mandated training (e.g., medical continuing education, equal employment opportunity, prevention of sexual harassment, etc.), the participants indicated that the requisite priority or emphasis on education and training is not demonstrated consistently at the Department-level. Participants emphasized this point by indicating the following:

- Department-level responsibility for education and training is often unclear or unknown.
- The Department reduces funding for education and training programs before similar reductions are taken in other program areas.
- Increased EEO complaints and labor grievances are perceived to be linked to a lack of Departmental supervisory training programs.
- Education and training interests are not represented adequately at the "planning table" for the Department.
- General supervisory support for education and training is currently in place, but most Administrations and Staff Offices have not allocated sufficient time for personnel to attend training programs.

2.2 Effective Planning

Strategic Issue 2: Effective planning for education and training programs needs to be strengthened and standardized throughout the Department.

While planning occurs in many forms throughout the Administrations, there appears to be no consistently applied and monitored planning process for education and training at the Department level. Participants emphasized this point by indicating the following:

- Effective learning strategies that address corporate career field education and training programs are incomplete.⁴

³ It is important to note that these strategies are not targeted toward the existing technical training efforts in place within each Administration. Instead, they are intended to improve and strengthen the coordination and Department-wide education and training efforts.

⁴ The terms Department-wide and corporate career fields refer to those administrative functions that exist across all Administrations and Staff Offices. Specifically, it refers to the following career fields: Information Technology, Human Resources, Public Affairs, Budget and Finance, and Acquisition.



- Department-level programs that provide Department-wide training (e.g., supervisor training, mission orientation) need to be established.
- The Department has not mapped the competencies or skills for many of its occupations.⁵
- Currently the creation, monitoring, and management of individual development plans (IDPs) are employed inconsistently throughout the Department.⁶
- Department-wide standards for education and training have yet to be established.
- The Departmental linkage between local, regional, and national education and training plans is often unknown or unclear.

2.3 Accountability

Strategic Issue 3: VA does not have a clear line of responsibility and accountability for the implementation of a comprehensive Department-wide education and training plan.

Participants in the assessment process repeatedly identified uncertainty regarding accountability throughout the Department-level management superstructure (first line supervisor to senior executive) for implementation of a comprehensive Department-wide education and training plan. The following statements collected during the assessment help to illustrate this uncertainty:

- There is no clear tie between education and training and the VA Strategic Plan.
- Departmental performance measures for education and training need to be established.
- The Department as a whole has yet to define measures relating to employee development in senior executive and upper management performance plans.
- The Department needs a more clearly defined central authority to implement training policy, and provide leadership and oversight.
- There is a lack of policy-mandated training plans for the Department.
- There is no system or tools in place for tracking, analyzing, and reporting training data to facilitate Departmental decision-making.

⁵ Competency and skill maps are tools used to organize the competencies and skills required to accomplish a job task successfully. The maps are usually created by collecting information on the relevance and importance of the task; the knowledge, skills and abilities required to perform the task; the rules, concepts and policies that apply to the task; and the steps involved in accomplishing the task.

⁶ It is important to note, however, that the use of IDPs has yet to be mandated by the Department.



2.4 Critical Gaps

Strategic Issue 4: Critical education and training gaps in leadership development and cross-cutting career fields need to be addressed.

Two areas were consistently singled out in the assessment as gaps in education and training programs at the Department level:

- Leadership Development (line supervisor to senior executive)
- Headquarters and field education training in cross-cutting career fields

Among the participants, it was regularly noted that while there were some excellent programs in the Administrations that support supervisory, management and leadership development, these programs have not been leveraged universally across the Department, nor meet any recognized Department standards. The result is a critical gap in the Departmental curriculum that supports the career advancement of current and future VA leaders (i.e., no clear “line of sight” for career advancement.)

Also noted was the need for effective programs to provide standardized education and training for personnel located at the Staff Offices and in cross-cutting career fields. There is no “basic” training for some specialties or a common baseline of knowledge coordinated at the Department level. The following findings help to illustrate this issue:

- The Department is facing a serious lack of qualified leaders, ranging from mid-level managers to senior executives, who are becoming eligible to retire.
- Few personnel in cross-cutting career fields across the Department attended education and training programs. The offerings provided were also fairly limited.⁷
- The Department’s annual budget does not strategically fund education and training programs for crosscutting career fields.

2.5 Communications

Strategic Issue 5: Department-wide communications regarding VA education and training programs need to be more effective.

The data indicates a considerable amount of confusion regarding current education and training programs as illustrated by the following:

- Senior leadership is unaware of some programs currently in place.
- Some participants in the assessment were unaware or unclear regarding some programs currently in place.
- The organizational location of VALU is unclear, and has created confusion among staff throughout the Department.

⁷ Acquisition Training is a notable exception.



3.0 Strategic Goals and Supporting Objectives

Based on the strategic issues identified in the previous section, the Working Group developed the following strategic goals and objectives. These goals and objectives represent the key elements of the ETP that will guide the Department forward in a coordinated manner to bring focus, accountability, and structure to education and training through effective planning and communications.

3.1 Strategic Transformation

Data collection efforts have shown that a solid foundation exists throughout the programs each Administration has developed to further the technical and professional competencies and skills required to accomplish their part of the Department's mission. The successful implementation of the VA Learning University (VALU) and growth of institutional programs such as Leadership VA has also created a basis for programs that span Department-wide in a strategic fashion.

The ETP takes these efforts and organizational strengths (See Section 4.1, page 14) and moves them forward to expand their strategies, elevate their importance, and institutionalize a new paradigm for education and training in VA. Through the strategic goals detailed in the following pages, the ETP will enable VA to respond better to the Department's Strategic Plan, and its enabling goal and objective to provide "world class service to veterans and their families" while "recruiting, developing, and retaining, a competent, committed, and diverse workforce."⁸

Furthermore, the ETP will help the VA's human capital planning efforts align with the goals of the Chief Human Capital Officers Act of 2002 by creating a structure, system of accountability, financial and human resources, policies, procedures and processes that will support effective workforce development strategies. This approach is targeted at reinforcing a culture of continuous learning that will attract and retain employees with superior abilities.⁹

Upon implementation of the ETP, the Department can expect:

- Clear Department-wide focus on education and training with consistent funding and support;
- Planning that will effectively address the education and training needs from a Department-wide perspective;
- A structure and system of accountability and responsibility to implement and sustain robust and successful Department-wide education and training programs;
- Closure in critical gaps affecting the development of VA employees in crosscutting career fields, and the subsequent generations of leaders to carry forward the mission of the Department without interruption; and
- A better-informed workforce and leadership, attuned to the educational offerings and the organizational framework supporting them.

⁸ VA Strategic Plan 2003-2007.

⁹ Homeland Security Act of 2003, Section 1402.



3.2 Strategic Goals

As mentioned earlier, each of the following goals have been developed in coordination with the VA Strategic Plan for 2003-2008, to ensure that they support the overall vision and mission of the Department:

- **Strategic Goal 1**
Identify and assign a Departmental organization to ensure education and training is incorporated into budget, resourcing, planning, and performance measurement.
- **Strategic Goal 2**
Ensure education and training plans are developed and aligned with human capital plans at all organizational levels as a part of the VA strategic planning cycle.
- **Strategic Goal 3**
Define and assign roles, responsibilities, and accountability structure clearly for VA education and training.
- **Strategic Goal 4**
Enhance existing leadership development and cross-cutting career field training programs to meet VA workforce needs.
- **Strategic Goal 5**
Develop and implement a communications and marketing plan to create a heightened awareness for employees at all levels on the full scope of learning opportunities.

3.3 Supporting Objectives

Derived from the strategic goals are the supporting objectives presented in Table 1 (page 12). Each objective describes how a goal can be attained through tactical action. These objectives will act as the initial step for the implementation phase of the strategic planning process. Further definition of the tactics that will be required for implementation can be found in Section 5.0 – Recommendations and Next Steps (page 20). Upon plan approval, these tactics will be expanded upon and incorporated into a comprehensive project plan.

**Table 1 – Strategic Goals and Supporting Objectives**

Strategic Goal #1	Identify and assign a Departmental organization to ensure education and training is incorporated into budget, resourcing, planning, and performance measurement.
High-level Objectives	<ol style="list-style-type: none"> 1. To oversee and coordinate the institutionalizing of education and training, the Department will establish an enduring office headed by a senior executive to champion and reinforce the initiatives identified in the Strategic Goals. 2. Design and implement a single governance structure for leadership of education and training for the Department. 3. Ensure adequate resources are allocated for education and training.
Strategic Goal #2	Ensure education and training plans are developed and aligned with human capital plans at all organizational levels as a part of the VA strategic planning cycle.
High-level Objectives	<ol style="list-style-type: none"> 1. Refine and implement a systematic planning cycle for the development of education and training plans linked to key annual planning cycles (e.g., budget, human capital, strategic). 2. Evaluate and measure effectiveness of education and training planning. 3. To implement HPDM more fully across the Department.
Strategic Goal #3	Define and assign roles, responsibilities, and accountability structure clearly for VA education and training.
High-level Objectives	<ol style="list-style-type: none"> 1. Develop and publish a revised VA training and education policy linked to strategic and human capital plans. 2. Define education and training performance measures for executives, managers, and supervisors relative to their levels of responsibility. 3. As a major component of the upcoming VA e-Learning Strategy, implement a Learning Management System (LMS) to capture and track education and training enterprise data for analysis and reporting (e.g., financial, production, learning history). 4. Anticipate and respond to emerging requirements (i.e., legislative, mandated, and mission-driven).



Strategic Goal #4	Enhance existing leadership development and cross-cutting career fields training programs to meet VA workforce needs.
<i>High-level Objectives</i>	<ol style="list-style-type: none"> 1. Identify VA-wide education and training standards for these programs (e.g., competencies, Instructional Systems Design models, and curriculum requirements). 2. Assess current program performance against the standards. 3. Develop and implement a curriculum for the cross-cutting career fields. 4. Implement short and long-term evaluation components to monitor ongoing performance in relation to the accepted standards.
Strategic Goal #5	Develop, implement, and maintain a communication and marketing plan to create a heightened awareness for employees at all levels on the full scope of learning opportunities.
<i>High-level Objectives</i>	<ol style="list-style-type: none"> 1. Develop a communication and marketing plan linked to the VA Education and Training Plan to disseminate information regarding employee education and development opportunities. 2. Implement, evaluate, and measure the effectiveness of the communication and marketing plan.



4.0 SWOT Analysis

The qualitative data collection efforts and facilitated sessions provided insight into the strengths, weaknesses, opportunities, and threats (“SWOT”) to a Department-wide education and training program. These four categories of influence will need to be considered throughout the implementation of the VA Education and Training Strategic Plan. Strengths and opportunities will provide the potential for “quick wins,” while weaknesses and threats will need to be addressed through a risk mitigation strategy.

4.1 Strengths

Strengths identified during the data collection process ranged from best practices to major Administration initiatives, indicating the success of individual education and training programs within the Department. Those strengths identified below will have a significant impact on the implementation of this strategic plan.

4.1.1 Infrastructure for Distance Learning

Within the Federal sector today, the VA is clearly a leader in the accessibility of technology-enabled learning. Through the VAKN satellite network, One Touch interactive Tele-training system, V-TEL videoconferencing capabilities, and VALO online offerings, employees can take advantage of educational offerings free of charge when and where they need them. Recently introduced, the Content Distribution Network (CDN) also provides access to video training content delivered directly to the employee’s desktop.

4.1.2 Administration-Specific Training

Another identified strength was the high quality of professional and technical training offered at the Administration, regional, and local levels. The analysis revealed that the unique nature of these environments necessitated training design, development, and delivery as administration-specific. The elements of the design and development efforts should be identified as models for future training programs, including those at the Department level and in corporate career fields.

4.1.3 The High Performance Development Model

The High Performance Development Model (HPDM), adopted Department-wide, defines core competencies for interpersonal and organizational excellence. This framework also includes 360-degree and 180-degree assessment tools that provide employees with feedback on individual strengths and opportunities for growth. On par with many corporate models, the coaching and mentoring element includes encouragement and development by an employee’s supervisor, rotations, team assignments, and learning events within the context of ongoing work. Recently adopted Department-wide, the HPDM provides a model for competency development and individual assessment for future training development. It will be important, furthermore, to incorporate HPDM tactically within the VA culture to maximize the Department’s investment in the model.



4.2 Weaknesses

The weaknesses identified below were further examined in the facilitated sessions. Some were elevated to strategic issues to ensure that they were addressed appropriately during implementation.

4.2.1 Lack of a Departmental Focus on Education and Training

Assessment participants consistently noted that the requisite priority or emphasis on education and training is not demonstrated consistently at the Department level. The participants in this effort often cited the lack of a Department Education and Training plan. While the administrations and Staff Offices may have plans, until now, there have been limited efforts to define Department-wide training needs.¹⁰

Another sign that the Departmental focus on education and training lacked solid backing was the absence of a process owner for education and training at the Department level, someone with a “seat at the table.” Opportunity and accessibility of training and education, furthermore, has also been noted as inconsistent throughout the Department because of “time away from work” and other resource-related concerns. Some assessment participants believe that a VA cultural shift towards solidifying and institutionalizing education and training across the Department is required, and that such a cultural change will result in improved services to the Nation’s veterans.

4.2.2 Lack of Department-wide Initiatives

There is a lack of training programs for cross-cutting career fields.¹¹ While the data collection revealed that most participants interviewed or surveyed believed that training should remain decentralized, a majority also felt that improved collaboration between administrations and Staff Offices would improve training programs for cross-cutting career fields. This was especially noted in leadership development programs. The Working Group has recognized the development of cross-cutting training as a strategic goal, identified the standardization of this training as a supporting objective, and emphasized the importance of better leveraging resources in the future.

¹⁰ A notable exception is the recent development of the VALU strategic learning priorities. These priorities include Career/Professional Development, Customer Service, Cross-Cutting Career Fields, Educating Employees Regarding Veterans, Emergency Preparedness, Employee Orientation/Reorientation, Information Management, Leadership and Management Development, Performance and Quality Improvement Tools and Methods, Personal Development, Quality of Work Life, Required Training, and University Degrees/Certificate Programs.

¹¹ As mentioned earlier, this excludes Acquisition Training, though opportunity and accessibility issues still apply (See Section 4.2.1 above).



4.2.3 Lack of Funding

Over time the budget for training and education in the Staff Offices has been cut with the expectation that the administrations would fund needed training. As recently as 10 years ago, Staff Offices had in place training programs in areas such as Human Resources and Finance, but over the past decade, these programs ceased to be funded due to budget cuts. As budget cuts become necessary from time to time within the Department, most surveyed believed that training resources were the first to be eliminated.

4.2.4 Lack of Department-Wide LMS

One final weakness noted was that the Department still does not have an enterprise Learning Management System (LMS) available to all employees and managers. Broadly defined, an LMS manages and facilitates the delivery of traditional and technology-enabled training, tracks student progress through the various types of training, and links training with required skills and competencies. As a centralized, Web-based application, the VA LMS is therefore envisioned as the nexus for all Departmental education and training opportunities.

Clearly, increasing the usage and effectiveness of training programs is critical to the development of a strong VA. An LMS would enable managers to provide employees with a single access point to all their training needs and allow blended delivery of the most effective learning methods. It would also allow collection of real-time data to support decision-making at both the Administration and Department levels. For these reasons, its criticality to Departmental education and training cannot be underestimated.

VA has been working on its LMS initiative for several years, and has been pursuing a highly configurable, commercial-off-the-shelf (COTS) application that would be available via the Intranet and Intranet. However, the recent e-Training initiative managed by OPM (known as "GoLearn") has been pursuing similar goals with the intent to provide centralized LMS services to the federal government. Since it has been unclear whether the services offered via GoLearn could meet the comprehensive and complex requirements of VA, the resulting protracted negotiations have led to the current acquisition and implementation delay.¹²

4.3 Opportunities

Assessment participants noted several opportunities for the advancement of training and education within the Department:

4.3.1 Technology-Enabled Learning

As identified in Section 4.1 (page 14), VA has in place a learning infrastructure that surpasses many government and private organizations. The ability to offer training in a variety of modalities will enable VA training managers to leverage technology-enabled learning across Department-wide training initiatives.

¹² The most recent negotiations between VA and GoLearn were on June 12, 2003. While there was agreement regarding the project's management structure and performance metrics, elements of the draft Inter Agency Agreement (IAA) relating to assumption of fiscal liability for cost overruns of the hosted solution were yet to be finalized. Signature authority for the IAA rests with the Deputy Secretary for VA.



With the variety of technologies now available for “blended” delivery, new and existing training is being converted to technology-enabled formats. For example, a significant amount of training in HPDM and leadership development uses a variety of learning technologies. VALU has also been asked to evaluate commercial distance learning products to extend the learning technology infrastructure even further.

VALO course modules can also be examined for blended opportunities, perhaps as pre-requisite or supplemental material to classroom or VAKN study.¹³ By examining job competencies, identifying knowledge and skills needed, then mapping critical tasks to training content, training managers can build a curriculum that addresses training needs and offers a variety of solutions to meet the needs of a population often limited in the amount of time that can be spent away from the job in the classroom.

4.3.2 Components of Leadership Development Training

Current leadership development programs continue to be improved and enhanced within the Department and Administrations. The Leadership VA (LVA) program was the most often mentioned success in the area of leadership development and inter-department collaboration. Other programs, listed below, are striving to prepare leaders for their future responsibilities within the Department:

- Leadership Advancement or “LEAD Program” (VBA and VHA);
- VHA Health Care Leadership Institute (HCLI);
- VBA Assistant Directors Development Program;
- Cemetery Director Training Program (NCA);
- Senior Executive Service (SES) Candidate Development Program.

These efforts can then become the foundation for the development of a VA leadership curriculum. Furthermore, by applying learning technology and linking the content with core leadership competencies, the content could then address a variety of learning styles through a more convenient blended solution.

4.3.3 Employee Orientation and Career Paths

The lack of a career path for most employees was often described as a weakness in the study. For example, it is unclear how an employee could determine their promotion potential, or which assignments to request to pursue career advancement. To address these issues, all VA employees need an understanding of learning expectations, opportunities, and career paths in their chosen field. This should include defined competencies as well as advancement or certification options. This career path should be determined as early as possible, beginning with a new employee orientation program that introduces new personnel to the organization and helps them to understand the mission of the organization and the constituents they serve. The program should also clearly define the goal of the VA to be the employer of choice, with a solid commitment to employee training and education.

¹³ VALO/VAKN is an example of a basic blended learning approach.



Leveraging the existing VA “Communities of Practice” – groups of people that have worked together for a period of time in a related area – could also help to define career paths by incorporating the issues and “lessons learned” encountered by the established career and skills-related communities within the Department. The implementation of an LMS, furthermore, will enable managers to build an individual development plan for each employee, mapping training opportunities and expectations to competencies, thereby enhancing career advancement. Each Administration and Staff Office can prepare for this implementation by designing and developing competencies for each grade level of that position and when appropriate, establishing certification procedures for employees in those occupations.

4.3.4 Communications and Marketing Learning Opportunities

The study noted that most employees are not aware of learning opportunities that are available to them. As VA implements the education and training plan for the Department, a marketing component must be included that will educate employees and managers of all the learning opportunities across the Department. This marketing/communication plan will inform employees and managers of the learning infrastructure in VA and the many opportunities for learning at their desktops. Again, a central goal of the marketing/communication should be to influence cultural changes in the VA towards institutionalizing education and training.

4.3.5 Leverage Department-wide Purchasing

As the largest civilian Department, VA has the ability to realize economies of scale and achieve greater management efficiencies by fully leveraging its purchasing power for training programs. For this reason, it is essential to eliminate practices that fragment the purchasing power for training programs and detract from the Department’s ability to achieve product consistency and obtain the most favorable terms and pricing.

4.3.6 Provide Clear Linkages to Human Capital Management

As mentioned earlier, the Chief Human Capital Officers Act focuses on ensuring the effective oversight of human resources, and directly supports the Department’s goal of recruiting, developing, and retaining a competent, committed, and diverse workforce. With such an alignment of legislative requirements and Departmental focus, there is an opportunity to highlight and reinforce this relationship through the Strategic Goals, recommendations, and “next steps” presented in the ETP.



4.4 Threats

Several threats were identified in the assessment phase of this project. These threats should be minimized as part of a risk mitigation strategy.

4.4.1 Placement of Education and Training Oversight

While the Office of Human Resources Management (OHRM) is responsible for education and training policy, it has played a limited role in the oversight of policy implementation and ongoing program evaluation. Current policy delegates substantial responsibility and accountability to the individual administrations and Staff Office heads. While the Administrations have managed their professional and technical training programs well, the lack of Departmental oversight has not ensured against redundancy of programs among the administrations, and a lack of training programs and resources for Staff Offices. The majority of survey, interview, and Working Group participants were very clear about the importance of proper placement of this oversight authority within the Department.

4.4.2 Insufficient or Poorly-Leveraged Resources

To demonstrate its commitment to education and training, the Department must protect funds and staffing levels allocated for education training and ensure that they are invested wisely in the development of an effective workforce. The Department must also work to make efficient use of available funds, leveraging its technological resources already in place with the implementation of a training development process that will meet and manage the needs of each employee. As the Department begins to map resources to training needs as identified in the strategic goals, more training and education can be delivered via alternative and blended modalities, providing more employees with access to training, when and where they need it. This effort, however, will require continued financial support and protected budgets for education and training.

4.4.3 Lack of Performance-based Measures

It is difficult to assess the effectiveness of training provided to both VA managers and employees because measures of effectiveness have to be better defined and applied across the Department. This was a repeated concern of executives interviewed, indicating that there are few formal measures in place linking training to an improvement in either individual or organizational performance. As the Department begins to address the objectives identified in the strategic goals, they will begin a process of establishing competencies and performance criteria by which to measure training efforts. By implementing a thorough evaluation plan (which will collect data that is in turn tracked and managed by the LMS), managers will have the information to link performance to organizational objectives.

4.4.4 Failure to Institutionalize and Champion Education and Training

The stability of any Departmental education and training program may be jeopardized if education and training is not institutionalized throughout the Department. To oversee and coordinate the institutionalizing of education and training, the Department will therefore need to establish an enduring office to champion and reinforce the initiatives identified in the Strategic Goals.



5.0 Recommendations and Next Steps

In consideration of the related ETP strengths, weaknesses, opportunities, and threats identified in Section 3.0 (page 10), the Working Group developed the following recommendations and suggested “next steps” for achieving the Strategic Goals and Supporting Objectives developed in Section 4.0 (page 14):

1. Establish an Office of Employee Education and Training headed by a senior executive to serve as the focal point for education and training in support of VA strategic management of human capital. Among its responsibilities, this office will:
 - a. Be responsible and accountable for departmental education and training policy, planning, evaluation, and oversight;
 - b. Be responsible for managing the programs currently managed under the umbrella of VALU;
 - c. Be responsible for leading a governance structure for education and training issues of departmental significance (e.g., funding for VA-wide program needs, vetting proposals for department-level training programs, etc.);
 - d. Be responsible for filling identified, department-level operational gaps:
 1. Leadership and supervisory development training
 2. Training programs for VACO Staff Offices and cross-cutting career fields
 3. Other training with VA-wide applicability (e.g., customer service training, new employee orientation, etc.)
2. Institutionalize education and training planning as a component of VA’s strategic planning and budgeting cycle to ensure adequacy of funding and alignment with Departmental strategic goals.
3. Complete implementation of initiatives critical to overall success of education and training within VA (recommended Office of Employee Education and Training should take a lead role):
 - a. High Performance Development Model (HPDM)
 - b. Learning Management System (LMS)
4. Decide on appropriate VA organizational alignment for Office of Education and Training – ideal is to associate this with the Chief Human Capital Officer because of the linkage between education and training and other programs central to strategic management of human capital.¹⁴

¹⁴ However, the office can function under any number of organizational configurations as long as its mission, role, responsibility, and authority are clear.



5. Take the following action as quickly as possible:
 - a. Approve, or modify and approve, the ETP.
 - b. Add the Chief Human Capital Officer (CHCO) to the VALU Board of Directors Executive Committee (helping ensure alignment with Human Capital Planning).
 - c. Assign responsibility to an interim executive for implementing the strategies and supporting objectives outlined in the ETP.
 - d. Develop an implementation plan that focuses on leadership and supervisory development training, training for cross-cutting career fields, and other training with VA-wide applicability (e.g., customer service and new employee orientation).
 - e. Expedite the acquisition of a Department-wide Learning Management System (LMS).
 - f. Ensure alignment between the ETP and ongoing education initiatives within the Department (e.g., e-Learning Strategy and Training Policy Revision).



Appendix A: Working Group, Interview, Focus Group, & Web Survey Participants

Working Group Participants

Working Group Member	Position/Organization
(b) (6)	Program Analyst, OI&T
(b) (6)	Deputy Chief of Staff
(b) (6)	Human Resource Manager, OI&T
(b) (6)	Executive/Workforce Planning & Development Officer
(b) (6)	Executive Assistant to VHA Chief Learning Officer
(b) (6)	Special Assistant to the Business Oversight Board
(b) (6)	Chief of Human Resources Division, NCA
(b) (6)	Special Assistant to the Director of Employee Development & Training
(b) (6)	Acting Dean of VALU and Chief Learning Officer of VHA
(b) (6)	Director of Employee Development and Training
(b) (6)	Director, HR Development
(b) (6)	Program Analyst, PP&P
(b) (6)	Director of Strategic Planning, PP&P
Selnick, Darin	Special Assistant and Associate Dean of VALU
(b) (6)	Management Analyst, OGC
(b) (6)	Education Program Manager, VALU
(b) (6)	Support, OGC

Interview Participants

Organization	Name	Position
VA	Dr. Leo Mackay	Deputy Secretary
	Nora Egan	Chief of Staff
VHA	Dr. Robert Roswell	Under Secretary for Health
	Dr. Jonathon Perlin	Deputy Under Secretary for Health
	Laura Miller	Deputy Under Secretary for Operation and Management
	Dr. Fran Murphy	Deputy Under Secretary for Health Policy Coordination
	Nevin Weaver	Chief of Staff
	Ken Clark	VISN 22 Network Director
	Jim Farsetta	VISN 3 Network Director
	(b) (6)	Acting Dean and Chief Learning Officer
NCA	Eric Benson	Acting Deputy Under Secretary for National Cemetery Administration
	(b) (6)	Acting Director of Field Operations in Memorial Affairs
VBA	Admiral Dan Cooper	Under Secretary for Benefits
	Bill Stinger	Acting Deputy Under Secretary for Benefits
	Bob Eply	Acting Deputy Under Secretary for Policy
	(b) (6)	Deputy Director of the Compensation and Pension Service
	(b) (6)	Director of Employee Development and Training
	(b) (6)	ADUS Office of Management
	(b) (6)	Area Director



Interview Participants (Continued)

Organization	Name	Position
Staff Offices & Cross-cutting Organizations	William H. Campbell	Assistant Secretary for Management
	David S. Derr	Acting DAS for Acquisition and Materiel Management
	Dennis Duffy	PDAS Policy Planning
	Dr. John Gauss	Assistant Secretary for Information Technology
	Gordon Mansfield	Assistant Secretary for Congressional Legislative Affairs
	Mark Catlett	PDAS for Management
	General Mick Kicklighter	Assistant Secretary for Policy and Planning
	Tim McClain	General Counsel
	Ventris Gibson	Deputy Assistant Secretary for Human Resources

Focus Group Participants

Organization	Name	Position
IG	Jon Wooditch	Assistant Inspector General
	(b) (6)	Director, Human Resources Mgmt Division
	(b) (6)	Deputy Assistant IG for Mgmt. & Administration
NCA	(b) (6)	Director, Mgmt. Support Services
	(b) (6)	Chief, Human Resources Div
OHRA	Bob Schultz	Principal DAS for HR&A
	Armando Rodriguez	DAS Diversity Management
	James Jones	DAS Resolution Management
OIT	(b) (6)	Dir., Office of Mgt.
	(b) (6)	Supervisory Computer Spec
	(b) (6)	Director, AAC
	(b) (6)	Human Resource Manager
	(b) (6)	Director, IT Support Services
OM	Jim Sullivan	Dep. Dir., OAEM
	Edward Murray	ADAS for Financial Systems
	(b) (6)	Core FLS Project Director
	(b) (6)	Executive Assistant
OPP	(b) (6)	Chief, Acquisition Training
	David Balland	Dep. Asst. Sec for Policy
	Gary Steinberg	Dep. Asst. Sec for Planning and Evaluation
VBA	(b) (6)	Director Loan Guaranty Service
	(b) (6)	Director Education Service
	(b) (6)	Director
	Stu Liff	Director, LA RO
	Monty Watson	Director, Montgomery RO
VHA	Dr. George Wolohojian	Director, Baltimore RO
	(b) (6)	Dir. Mgmt. Support Office
	Linda Belton	Dir. VISN 11
	(b) (6)	EES Integration Council
	Jonathan Gardner	Dir., VAMC Tucson



Focus Group Participants (Continued)

Organization	Name	Position
VHA	(b) (6)	Exec. Asst. Patient Care Services
	Max Lewis	Asst. Dep. Under Sec. Health Operations & Management
	(b) (6)	Chief of A&MM
	Larry Flesh	Network Medical Director
	Kimberly Jones	VA Western New York LPN
VHA / VALU	(b) (6)	Exec. Dir., Leadership VA
EES/VHA	(b) (6)	Managing Director
AFGE	(b) (6)	AFGE Local 1539 President
Union	5 Respondents	Union Representatives

Web Survey Recipients ¹

Organization	Name	Position
OHRA	(b) (6)	Training Mgr. Ofc. Resolution Management
OIT	Bruce Brody	ADAS for Computer Security
	(b) (6)	Director, IT Oversight
		Staff Assistant
		Program Analyst
OM		Materiel Management Specialist
	Rita Reed	DAS for Budget
	(b) (6)	Dep. Dir.
		Director of the Enterprise
		Lead Program Analyst
		Program Analyst
		Director
		Executive Director
		Executive Assistant
	Rom Mascetti	ADAS Financial Policy
	(b) (6)	Cost and Debt Mgt
		Cost Accounting and Medical
		Director, Accounting/Payroll
		Director, Acquisition Resources Service
		Director, Business Office
VBA	(b) (6)	Special Assistant to the Director of Employee Development & Training
VHA		Personnel Mgt Spec
		HR Consultant
		Chief, EEO/Civil Rights Policy Team
		Dir., Iron Mountain VAMC
		Acting Dir., Field Operations Div, EES
		Acting Dir., Admin Operations, EES
		Exec. Asst. to VHA CLO
		National Initiatives Div. Consultant

¹ Softcopy of the textual responses to the Web Survey are available upon request.



Appendix B: Government Furnished Information (GFI) Inventory

Index	GFI Title	File Name	Date Received	GFI Type
1	Charter for VA E-Learning Strategy Committee	Charter for VA Elearning Strategy.doc	3/13/03	Word Document
2	VA-wide Education and Training	education and training task order October 5.ppt	3/13/03	PowerPoint Slides
3	EES' Content Distribution Network Team Wins Network World's 2002 User Excellence Award	EES.doc	3/13/03	Word Document
4	EES FY03 National Training Priority Setting Process	EES FY03 National Training Priority Setting Process.doc	3/13/03	Word Document
5	VA e-Learning Strategy (draft)	e-learning strategy draft 15f3.doc	3/13/03	Word Document
6	Succession Planning for Engineers and Safety Professionals	Engineering Succession Planning.pdf	3/13/03	Adobe Acrobat File
7	EES FY03 National Training Priority Areas	FY03 Priority Areas description.doc	3/13/03	Word Document
8	Department of Veterans Affairs Strategic Plan: FY2001 – 2006	GAO_ VA Strategic Plan.htm	3/13/03	HTML File
9	VHA NATIONAL STRATEGIC PLANNING GUIDANCE: FY 2003–FY 2007	GAO_VHA NATIONAL STRATEGIC PLANNING GUIDANCE.doc	3/13/03	Word Document
10	SUMMARY OF HC ASSESSMENT STRATEGIES	HC Strats1+ Team Assignments.doc	3/13/03	Word Document
11	Model Human Resources Specialist Career Path	HR Career Training Tables.doc	3/13/03	Word Document
12	NATIONAL LEADERSHIP DEVELOPMENT PROGRAMS	Leadershipgrid 11-02.xls	3/13/03	Excel Spreadsheet
13	VA LEARNING UNIVERSITY OPERATIONAL PLAN	Operational Plan2.doc	3/13/03	Word Document
14	Employer of Choice	performance measure.doc	3/13/03	Word Document
15	Professional Development – Task Group Report	Professional Development Task Group Report-Final.doc	3/13/03	Word Document
16	President's Management Agenda – Scorecard Update	Scorecard update11 -- post performance review 9.30.doc	3/13/03	Word Document

VA Education and Training Strategic Plan



Index	GFI Title	File Name	Date Received	GFI Type
17	Sect1 – HCAAT	Sect1-HCAAT.doc	3/13/03	Word Document
18	Department-Wide Professional Development	Slides revised 1-3-01version 2.ppt	3/13/03	PowerPoint Slides
19	VA LEARNING UNIVERSITY STRATEGIC PLAN	VA Learning University.doc	3/13/03	Word Document
20	EXECUTIVE DECISION MEMO – VA Strategic Learning Priorities	VA Strategic Learning Priorities 2	3/13/03	Word Document
21	VALU BOD Organizational Charter	VALU BOD Charter (revised)	3/13/03	Word Document
22	Background Information in support of the Professional Development Task Group Recommendations (January 2002)	N/A – Hardcopy Only	3/14/03	Hardcopy
23	The Next Generation Work Group – Findings, Recommendations, and Summary	N/A – Hardcopy Only	3/14/03	Hardcopy
24	VA Learning University – VALU Implementation Plan (7/7/95, the “Moravec” Report)	N/A – Hardcopy Only	3/14/03	Hardcopy
25	Department of Veterans Affairs Workforce and Succession Planning (1/10/02)	N/A – Hardcopy Only	3/14/03	Hardcopy Slide Presentation
26	Decision Paper – “One-VA Training System” (1995)	N/A – Hardcopy Only	3/14/03	Hardcopy
27	DOIU – Department of the Interior University	N/A – Hardcopy Only	3/14/03	Hardcopy Brochure
28	Orientation to TVA University (2003)	N/A – Hardcopy Only	3/14/03	Hardcopy
29	VA Learning University – Implementation Action Plan (March 22, 1999)	N/A – Hardcopy Only	3/19/03	Hardcopy
30	Guide for Using the VSSC Data Site	VSSC Data Guide.doc	3/20/03	Word Document
31	Projection Instructions	Projection Instructions.xls	3/20/03	Excel Spreadsheet
32	Workforce and Succession Planning: Preparation of Organizational Plans	wfpguidance – final.doc	3/20/03	Word Document

VA Education and Training Strategic Plan



Index	GFI Title	File Name	Date Received	GFI Type
33	VA Directive 5002 -- DEPARTMENT OF VETERANS AFFAIRS (VA) WORKFORCE AND SUCCESSION PLANNING	wfpdirective – final.doc	3/20/03	Word Document
34	The High Performance Development Model (various printouts from VA Intranet)	N/A – Hardcopy Only	3/24/03	HTML Printouts
35	Milestone 1 Review Program Decision Briefing – VA Learning Management System (dated: 2/5/2003)	N/A – Hardcopy Only	3/24/03	PowerPoint Presentation
36	VA Directive 5015 – Employee Development	5015_Employee_Development.doc	3/25/03	Word Document
37	e-Learning 200 and Beyond – The State of the Industry (Corporate University Xchange, Inc., 2000)	elearning.pdf	3/25/03	Adobe Acrobat File
38	HPDM Brochure 1 from VA Intranet	hpdm.pdf	3/25/03	Adobe Acrobat File
39	HPDM Brochure 2 from VA Intranet	hpdm2.pdf	3/25/03	Adobe Acrobat File
40	HPDM – Core Competency Definitions & Behavioral Examples at Each Level	corecompetencydefinitions.pdf	3/25/03	Adobe Acrobat File
41	National Cemetery Administration – FY2001 – FY 2006 NCA Strategic Plan	NCAPlan20012006.doc	3/25/03	Word Document
42	National Cemetery Administration – Employee Training Delegation of Authority Memorandum	Training ApprovalDelegation.doc	3/25/03	Word Document
43	National Cemetery Administration – Training and Education Guidance (Draft SOP)	Training SOP(draft).doc	3/25/03	Word Document
44	HPDM Systems Thinking	Self-Study8-Systems_Thinking.doc	5/02/03	Word Document
45	HPDM Organizational Stewardship	Self-Study9-Organizational_Stewardship.doc	5/02/03	Word Document
46	HPDM Interpersonal Effectiveness	Self-Study4-Interpersonal_Effectiveness.doc	5/02/03	Word Document
47	VA Factor Analysis	VAFactor_Items_9_02.doc	5/02/03	Word Document
48	VHA Executive Resources Board Overview	2003aECF_Program_Overview.doc	5/02/03	Word Document

VA Education and Training Strategic Plan



Index	GFI Title	File Name	Date Received	GFI Type
49	VHA Executive Resources Board App Process	2003b_ECF_Application_Process.doc	5/02/03	Word Document
50	VHA Executive Resources Board Program Description	2003b_ECF_Development_Program_Description.doc	5/02/03	Word Document
51	VHA Workforce Succession Plan 2003-2007	VHA WF Succ Plan Draft 4_2_03am.doc	5/02/03	Word Document
52	Technical Career Fields Program Overview and Proposed Elements	NLB_Proposal_11_13_02.doc	5/02/03	Word Document
53	Mentoring Toolbox	mentoring_toolbox.doc	5/02/03	Word Document
54	VHA VISN/Facility Leadership Development Program	LEAD_DRAFT_REPORT_FINAL.doc	5/02/03	Word Document
55	EES IDP Policy Draft	EESIDPPolicydraft.doc	6/10/03	Word Document

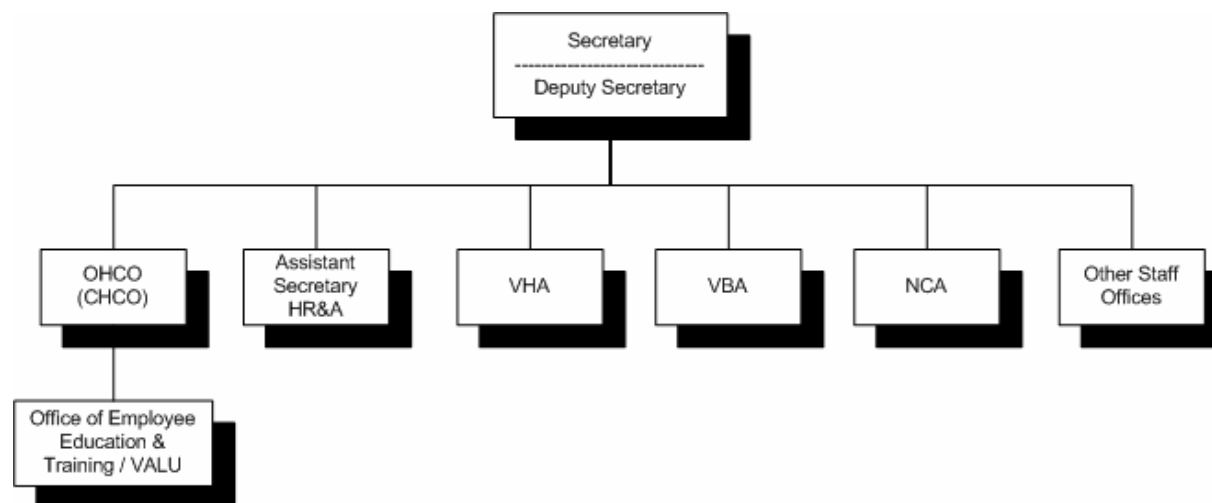


Appendix C: Proposed VALU Alternatives

Proposed Alternative Scenario #1

Establish an Office of Human Capital (OHC), reporting to the Secretary

Organizational Specifics	Strengths	Weaknesses
<ul style="list-style-type: none"> Office of Human Capital, headed by an executive level CHCO, is not part of HR&A. It is a separate organization reporting to the Secretary Office of Employee Education and Training (OET)/VALU, OHRM training and policy function, and OHRM workforce planning reports to the CHCO CHCO is Department Chief Learning Officer (CLO) Will require revisiting the department decision not to make the Human Capital Officer separate from the Assistant Secretary for HR&A (AS/HR&A) CHCO does not have line authority over administration CLOs A cross-organizational governance structure will continue to exist 	<ul style="list-style-type: none"> Meets strategic issues and Department needs Ensures a corporate identity separate from VHA. Integrates key Human Capital components Demonstrates department commitment to learning Possesses sufficient authority to implement change Avoids perceived institutional bias surrounding HR Meets the legislative intent of the Human Capital legislation Creates a VA-wide learning system Has a seat at the table Is a fresh start Places corporate education in a more strategic position Facilitates coordination of education and educational policy 	<ul style="list-style-type: none"> Requires another direct report to the Secretary Requires start up funds Invites congressional scrutiny Subjects the Office to the constraints of the GOE budget Requires reporting to the Office of the Secretary which makes the Office vulnerable to administration changes Raises confusion regarding roles of Human Capital and HR Weakens HC Officer by fragmenting the HR functional responsibilities Raises issues of SES cap



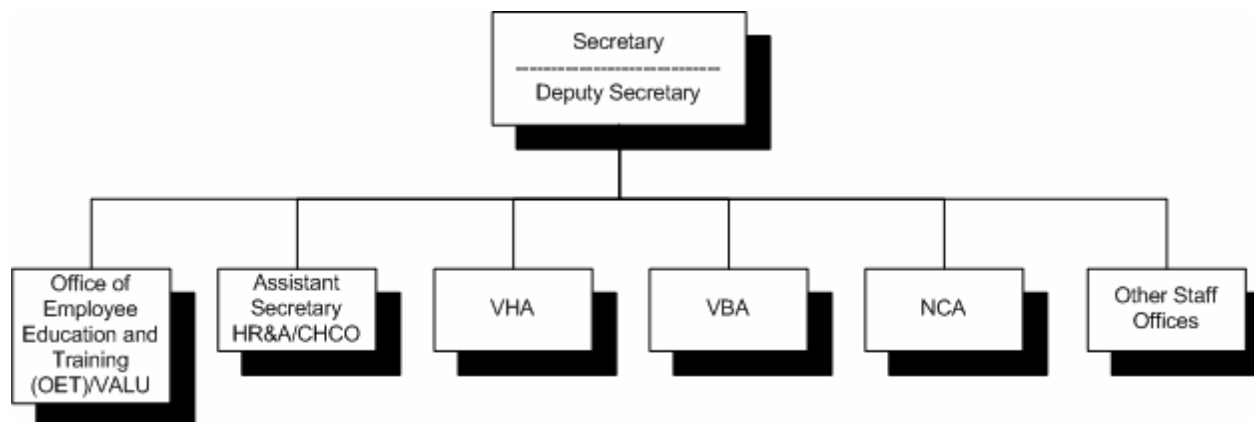
Appendix C: Proposed VALU Alternatives



Proposed Alternative Scenario #2

Establish Office of Employee Education and Training (OET), reporting to the Secretary

Organizational Specifics	Strengths	Weaknesses
<ul style="list-style-type: none"> Office of Employee Education and Training (OET) head becomes the department CLO, reports to the Office of the Secretary OET head is a separate SES position from VHACLO SES OHRM training and policy function moves under OET VALU becomes a component of OET AS/HR&A/CHCO stays separate office Department CLO does not have line authority over administration CLOs A cross-organizational governance structure will continue to exist 	<ul style="list-style-type: none"> Meets strategic issues and Department needs Ensures a corporate identity separate from VHA. Demonstrates department commitment to learning Possesses sufficient authority to implement change Avoids perceived institutional bias surrounding HR Creates a VA-wide learning system Has a seat at the table Is a fresh new start Places corporate education in a more strategic position Is singly focused on education and training 	<ul style="list-style-type: none"> Requires another direct report to the Secretary Separates learning from Human Capital Officer functions Lacks line authority which makes it difficult to coordinate administration and Staff Office efforts Requires start up funds Invites congressional scrutiny Subjects the Office to the constraints GOE budget Requires reporting to the Office of the Secretary makes the Office vulnerable to administration changes Raises issues of SES cap



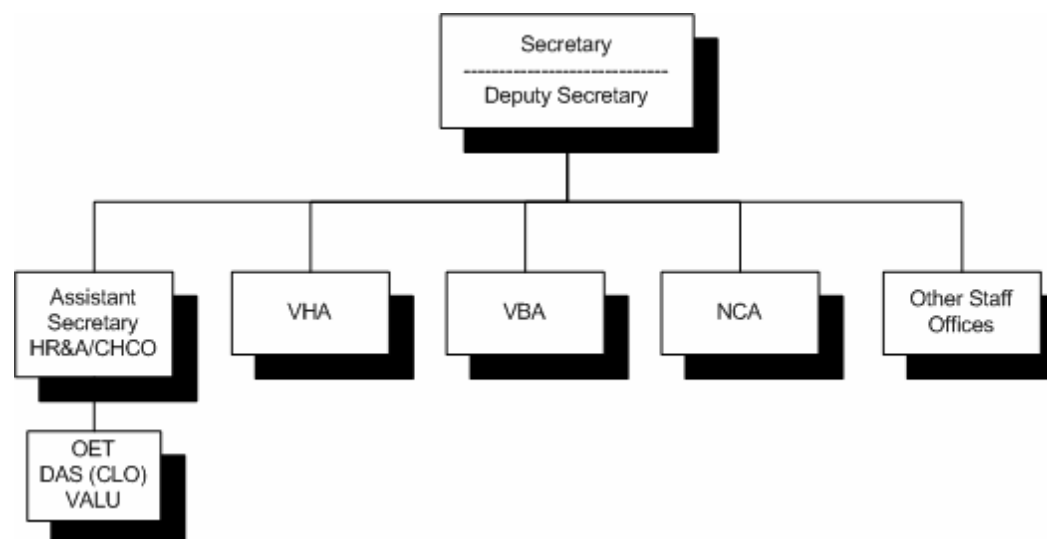


Appendix C: Proposed VALU Alternatives

Proposed Alternative Scenario #3

Establish Office of Employee Education and Training (OET), reporting to Asst. Secretary HR&A/CHCO

Organizational Specifics	Strengths	Weaknesses
<ul style="list-style-type: none"> DAS for E&T Office reports to the AS/HR&A/CHCO, and is the CLO VALU and OHRM training and policy function report to the CHCO A cross-organizational governance structure will continue to exist Department CLO does not have line authority over administration CLOs 	<ul style="list-style-type: none"> Meets strategic issues and Department needs Ensures a corporate identity separate from VHA Integrates all key Human Capital components under CHCO Demonstrates department commitment to learning Possesses sufficient authority to implement change Meets the legislative intent of the Human Capital legislation Creates a VA-wide learning system Is a fresh new start Places corporate education policy in a more strategic position Minimizes start up costs and organizational disruption 	<ul style="list-style-type: none"> Requires new DAS position and issues of SES and DAS cap Subjects the Office to the constraints GOE budget Lacks line authority which makes it difficult to coordinate administration and Staff Office efforts Does not address the institutional bias surrounding HR&A Makes education and training compete with other HR&A functions No seat at the table

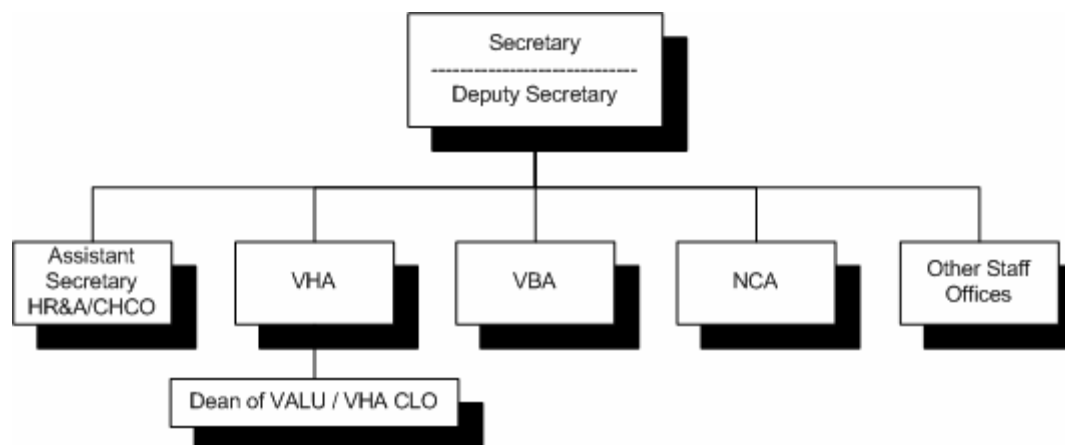


Appendix C: Proposed VALU Alternatives



Proposed Alternative Scenario #4
 Preserve Current Organizational Structure

Organizational Specifics	Strengths	Weaknesses
<ul style="list-style-type: none"> Dean of VALU also CLO VHA/EES Dean of VALU does not have line authority over other administration CLOs A cross-organizational governance structure will continue to exist CHCO is the AS/HR&A reporting to the Secretary OHRM retains Department training policy responsibility 	<ul style="list-style-type: none"> Existing organization with a track record of developing, and implementing educational infrastructure (VAKN, VALO, Online Catalog, etc.) Leverages existing VHA and EES resources to the benefit of the Department No start up costs or organizational disruption Saves an SES slot by keeping the dual position 	<ul style="list-style-type: none"> Does not address strategic issues and Department needs Does not ensure a corporate identity separate from VALU Does not demonstrate department commitment to learning Has insufficient authority to implement change No seat at the table Is subject to VHA influence Training policy and oversight functions are separate from CLO position.







DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

August 24, 2019

In Reply Refer To: 001B
FOIA Request: 18-11960-F

Daniel McGrath, Staff Attorney
Austin Evers, Executive Director
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005
foia@americanoversight.org; daniel.mcgrath@americanoversight.org

Dear Mr. McGrath:

This is the Seventh Partial Initial Agency Decision (IAD) to your Freedom of Information Act (FOIA) request to the Office of the Secretary, U.S. Dept. of Veterans Affairs (OSVA) dated and received August 23, 2018, and assigned FOIA tracking number **18-11960-F**. You requested: All records reflecting communications (including emails, email attachments, text messages, messages on messaging platforms (such as Slack, GChat or Google Hangouts, Lync, Skype, or WhatsApp), telephone call logs, calendar invitations/entries, meeting notices, meeting agendas, informational material, talking points, any handwritten or electronic notes taken during any oral communications, summaries of any oral communications, or other materials) between any of the individuals listed

- Veterans Affairs Officials
 - Darin Selnick, Senior Advisor to the Secretary
 - Casin Spero, Special Advisor
 - Individuals within the Offices of the Secretary and Deputy Secretary: David Shulkin, Former Secretary, and anyone acting on his behalf
 - Vivieca Wright Simpson, Former Chief of Staff
 - Pete O'Rourke, Former Chief of Staff, Former Acting Secretary, and Senior Advisor to the Secretary; and anyone acting on his behalf
 - Robert Wilkie, Secretary, and anyone acting on his behalf
 - Jacquelyn Hayes-Byrd, Acting Chief of Staff and Deputy Chief of Staff
 - Thomas Bowman, Deputy Secretary, and anyone acting on his behalf
 - Any political appointee* in the immediate Office of the Secretary or Deputy Secretary during the applicable time period not previously listed above
- Outside Recipients
 - Dan Caldwell
 - Nathan Anderson
 - Shannon Hough
 - Pete Hegseth
 - Any email address ending in @cv4a.org or @cvafoundation.org
 - Isaac "Ike" Perlmutter
 - Bruce Moskowitz
 - Marc Sherman
- All email communications between any of the individuals listed in Column A and any external individuals or organizations (i.e., emails with addresses ending in com/.org/.net/.mil/.edu) that mention one or more of the following search terms in the subject line, body of the email, or attachment:
 - a. "Concerned Veterans"
 - b. "Concerned Vets"
 - c. CVA

d. CV4A

Please provide all responsive records from January 20, 2017, through the date of the search.”

There is substantial overlap between FOIA request **18-11960-F** and your prior FOIA request **18-07426-F**, as there are responsive records responsive to both FOIA requests.

18-11960-F: 7th Partial IAD & Reasonable Searches Dated 12/19/18 & 5/2/19

On December 19, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below twelve (12) custodians from January 20, 2017, to December 19, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Byrne, Jim, current VA Acting Deputy Secretary;
- 5) Bowman, Thomas, former VA Deputy Secretary;
- 6) Powers, Pam, current VA Chief of Staff;
- 7) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 8) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 9) Selnick, Darin, former VA White House Senior Advisor;
- 10) Lukach, Michael, former VA White House Senior Advisor;
- 11) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 12) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On May 2, 2019, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms “Concerned Veterans of America,” “CVA,” “cv4a.org,” “CV4A,” “Concerned Vets,” and “Concerned Veterans” to search through the email boxes of the aforementioned twelve (12) custodians. Excluding the previous Clearwell search results for the First through Third Partial Initial Agency Decisions, this May 2, 2019, Clearwell search yielded approximately two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages.

Of the two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages, OSVA now releases twenty-eight (28) emails and their attachments totaling eight hundred ninety-five (895) pages, Bates-numbered 5178-6672. After reviewing the six hundred forty-nine (649) pages, OSVA redacts some information with FOIA Exemption 6.

5 U.S.C. § 552(b)(6) exempts from required disclosure “personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.” FOIA Exemption 6 permits VA to withhold a document or information within a document if disclosure of the information, either by itself or in conjunction with other information available to either the public or the FOIA requester, would result in an unwarranted invasion of an individual’s personal privacy without contributing significantly to the public’s understanding of the activities of the federal government. Specifically, the information being withheld, as indicated on the enclosed documents, under FOIA Exemption 6, consists of names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal employees and private citizens; we however release the names and VA email addresses of VA Senior Executives. Federal civilian employees and private citizens retain a significant privacy interest under certain circumstances, such as in instances where the release of their information could represent a threat to their well-being, harassment, or their ability to function

within their sphere of employment. The federal civilian employees and private citizens whose information is at issue have a substantial privacy interest in their personal information. In weighing the private versus the public interest, except names and VA email addresses of VA Senior Executives, we find that there is no public interest in knowing the names, identities, email addresses, VA usernames, phone numbers, cellular numbers, and facsimile numbers of federal civilian employees and private citizens. The coverage of FOIA Exemption 6 is absolute unless the FOIA requester can demonstrate a countervailing public interest in the requested information by demonstrating that the individual is in a position to provide the requested information to members of the general public and that the information requested contributes significantly to the public's understanding of the activities of the Federal government. Additionally, the requester must demonstrate how the public's need to understand the information significantly outweighs the privacy interest of the person to whom the information pertains. Upon consideration of the records, I have not been able to identify a countervailing public interest of sufficient magnitude to outweigh the privacy interest of the individuals whose names are redacted. The protected information has been redacted and (b)(6) inserted. Releasing even a single VA username reveals the pattern to ascertain VA usernames that VA employees use to log into VA Systems of Records; releasing VA usernames exposes the VA, its employees, and its contractors to potential hacking and information technology security liabilities and risks. "Withholding a telephone number or e-mail address, alone, is not sufficient to protect that [privacy] interest; alternate means of contacting and harassing these employees would be readily discoverable on the Internet if this court ordered their names disclosed." Long v. Immigration & Customs Enft., 2017 U.S. Dist. LEXIS 160719 (D.C. Cir. 2017).

Thus far, OSVA has released to you six thousand five hundred twenty (6,520) pages for FOIA requests **18-07426-F** and **18-11960-F**.

18-11960-F: 6th Partial IAD & Reasonable Searches Dated 12/19/18 & 5/2/19

On December 19, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below twelve (12) custodians from January 20, 2017, to December 19, 2018:

- 13) Wilkie, Robert L., Jr., VA Secretary;
- 14) Shulkin, David, former VA Secretary;
- 15) O'Rourke, Peter M., former VA Acting Secretary;
- 16) Byrne, Jim, current VA Acting Deputy Secretary;
- 17) Bowman, Thomas, former VA Deputy Secretary;
- 18) Powers, Pam, current VA Chief of Staff;
- 19) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 20) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 21) Selnick, Darin, former VA White House Senior Advisor;
- 22) Lukach, Michael, former VA White House Senior Advisor;
- 23) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 24) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On May 2, 2019, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms "Concerned Veterans of America," "CVA," "cv4a.org," "CV4A," "Concerned Vets," and "Concerned Veterans" to search through the email boxes of the aforementioned twelve (12) custodians. Excluding the previous Clearwell search results for the First through Third Partial

Initial Agency Decisions, this May 2, 2019, Clearwell search yielded approximately two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages.

Of the two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages, on July 8, 2019, OSVA released thirty-two (32) emails and their attachments totaling six hundred forty-nine (649) pages, Bates-numbered 5129-5777. After reviewing the six hundred forty-nine (649) pages, OSVA redacted some information with FOIA Exemptions 5 and 6.

Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts portions of deliberations requiring press releases and Mission Act policies. The redacted information is both predecisional and deliberative because it reflects preliminary opinions and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996).

18-11960-F: 5/10/19, 5th Partial IAD

On May 10, 2019, after re-reconsidering OSVA's FOIA Exemption 5 redactions to pages Bates-numbered 1003-1005 and 1124-1132, OSVA no longer redacts them per FOIA Exemption 5.

On May 10, 2019, after re-considering OSVA's FOIA Exemption 5 redactions to a briefing memorandum and talking points (Bates-numbered 1030-1031), OSVA still believes those redactions are warranted. Exemption 5 permits an agency to withhold material reflecting the thoughts, opinions, and recommendations of federal officials reviewing an issue. Under the deliberative process privilege and FOIA Exemption 5, OSVA redacts portions of talking points and a briefing memorandum prepared for Secretary Shulkin for his meeting with Rep. Cathy McMorris-Rodgers. The redacted information is both predecisional and deliberative because it reflects preliminary opinions and recommendations, which do not reflect VA's final decision. Exposure of premature discussions before a final decision is made could create undue public confusion. The release of the redacted information would negatively impact the ability of federal employees to openly and frankly consider issues amongst themselves when deliberating, discussing, reviewing, and making recommendations on VA programs. The information reveals the thoughts, deliberations, and opinions that, if released, would have a chilling effect on the ability of federal officials to discuss, opine, recommend or be forthcoming about the agency's issues which require full and frank assessment. Here, the disclosure of the withheld information is likely to compromise the integrity of this deliberative or decision-making process. Moreover, the predecisional character of a document is not altered by the passage of time. Bruscino v. BOP, No. 94-1955, 1995 WL 444406 at *5 (D.D. C. May 15, 1995), aff'd in part, No. 95-5212, 1996 WL 393101 (D.C. Cir. June 24, 1996); Access Reports v. DOJ, 926 F.2d 1192, 1196-97 (D.C. Cir. 1991) ("talking points" memoranda are predecisional); ACLU v.

DHS, 738 F. Supp. 2d 93, 112 (D.D.C. 2010) ("‘talking points’ are predecisional . . . the document itself suggests that a public statement was anticipated at the time of its creation, and given that no official statement has yet been made, the talking points remain ripe recommendations that are ready for adoption or rejection by the Department"); Sec. Fin. Life Ins. Co., No. 03-102-SBC, 2005 WL 839543, at *11 (D.D.C. Apr. 12, 2005) ("The undisputed evidence establishes that these [talking points] are deliberative"); Judicial Watch, Inc. v. U.S. Dep’t of Commerce, 337 F. Supp. 2d 146, 174 (D.D.C. 2004) (protecting "talking points" and recommendations on how to answer questions); St. Louis Sewer Dist., No. 10-2103, at *18 (E.D. Mo. Mar. 2, 2012) (protecting e-mail communications, "press releases, talking points and 'Q & A,' drafts, and briefing materials"); Citizens for Responsibility & Ethics in Wash. v. DHS, 514 F. Supp. 2d 36, 44 (D.D.C. 2007) (protecting briefing materials concerning Hurricane Katrina response including proposed "solutions and approaches"); Judicial Watch, Inc. v. DOE, 310 F. Supp. 2d 271, 317 (D.D.C. 2004) (protecting briefing materials for Secretary of the Interior), aff’d in part, rev’d in part on other grounds & remanded, 412 F.3d 125, 133 (D.C. Cir. 2005); Klunzinger v. IRS, 27 F. Supp. 2d 1015, 1026 (W.D. 1998) (protecting paper to brief commissioner for meeting); Thompson v. Dep’t of the Navy, No. 95-347, 1997 WL 527344, at *4 (D.D.C. Aug. 18, 1997) (protecting materials to brief senior officials responding to media inquiries, as "disclosure of materials reflecting the process by which the Navy formulates its policy concerning statements to and interactions with the press" could stifle frank communication within the agency), aff’d, No. 97-5292, 1998 WL 202253, at *1 (D.C. Cir. Mar. 11, 1998) (per curiam); Williams v. DOJ, 556 F. Supp. 63, 65 (D.D.C. 1982) (protecting "briefing papers prepared for the Attorney General prior to an appearance before a congressional committee").

18-11960-F: 5/8/19, 4th Partial IAD & Reasonable Searches Dated 12/19/18 & 5/2/19

From the aforementioned searches dated December 19, 2018, and May 2, 2019, yielding approximately two hundred twenty (220) emails and their attachments totaling approximately five thousand (5,000) pages, OSVA released fourteen (14) emails and their attachments totaling five hundred seventy-four (574) pages, Bates-numbered as 4555-5128 on May 8, 2019. On May 8, 2019, after reviewing the five hundred seventy-four (574) pages, OSVA redacted some information with FOIA Exemptions 5 and 6.

5 U.S.C. § 552(b)(5) exempts from required disclosure "inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency." Under the attorney-client and work product privileges, the VA redacted portions of records, emails, and communications between VA employees and attorneys relating to federal lawsuits against the VA. The release of this information would impede the ability of VA employees and attorneys to speak openly and frankly about legal issues concerning lawsuits against the VA. The release of this information would also compromise the VA's legal positions for its lawsuits.

18-11960-F: 5/2/19, 3rd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

On September 6, 2018, the OSVA FOIA Officer requested that the VA IT office search through the email boxes of the below ten (10) custodians from January 20, 2017, to September 6, 2018:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) Shulkin, David, former VA Secretary;
- 3) O'Rourke, Peter M., former VA Acting Secretary;
- 4) Bowman, Thomas, former VA Deputy Secretary;
- 5) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 6) Wright-Simpson, Vivieca, former VA Chief of Staff;

- 7) Selnick, Darin, former VA White House Senior Advisor;
- 8) Lukach, Michael, former VA White House Senior Advisor;
- 9) Leinenkugel, Jake, former VA White House Senior Advisor; and,
- 10) Spero, Casin D, former VA White House Liaison.

The VA IT office provided search results, with the OSVA FOIA Officer to conduct secondary searches via the Clearwell e-discovery platform.

On September 11, 2018, using the Clearwell e-discovery platform, the OSVA FOIA Officer used the key terms “Concerned Veterans of America,” “CVA,” and “cv4a.org” to search the email boxes of: former VA Secretary David Shulkin, Robert Wilkie, Peter O’Rourke, Thomas Bowman, Jacquelyn Hayes-Byrd, Vivieca Wright-Simpson, Darin Selnick, Michael Lukach, Jake Leinenkugel, and Casin Spero. This Clearwell search yielded one hundred eighty-two (182) documents totaling three thousand five hundred thirty-one (3,531) pages.

On November 30, 2018, OSVA released to you one hundred seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), redacted with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). On February 14, 2019, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, redacted with FOIA Exemptions 5 and 6.

18-11960-F: 2/14/19, 2nd Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

From the aforementioned searches dated September 6, 2018, and September 11, 2018, OSVA released three (3) documents and their attachments totaling seven (7) pages, Bates-numbered as 4548-4554, on February 14, 2019, redacted with FOIA Exemptions 5 and 6.

18-11960-F: 11/30/18, Initial Partial IAD & Reasonable Searches Dated 9/6/18 & 9/11/18

Of the searches dated September 6, 2018, and September 11, 2018, OSVA released seventy-nine (179) documents totaling three thousand five hundred twenty-four (3,524) pages on November 30, 2018, Bates-numbered as 996-4547 (with 1508-1535 intentionally left blank), on November 30, 2018.

After reviewing the three thousand five hundred twenty-four (3,524) pages, OSVA redacted some information with FOIA Exemptions 4, 5, 6, 7(C), and 7(E). 5 U.S.C. § 552(b)(4) exempts from disclosure “trade secrets and commercial or financial information obtained from a person and privileged or confidential.” Redacted information includes voluntary proposal submission verbiage, technical processes, technical approaches, and partnership or subcontracting agreements. The release of this information would likely lead to substantial competitive harm in reverse-engineering of the vendors’ technical approaches, processes, partnership, subcontracting, and business and labor strategies. RMS Indus. v. DOD, No. C-92-1545, slip op. at 7 (N.D. Cal. Nov. 24, 1992) (protecting “descriptions of equipment and the names of contacts, customers, key employees, and subcontractors” because “bidders only submit such information if it will not be released to their competitors”); BDM Corp. v. SBA, 2 Gov’t Disclosure Serv. (P-H) ¶ 81,189, at 81,495 (D.D.C. Mar. 20, 1981) (protecting names of consultants and subcontractors, performance, cost, and equipment information).

5 U.S.C. § 552(b)(7)(C) exempts from required disclosure information law enforcement information the disclosure of which “could reasonably be expected to constitute an unwarranted invasion of personal privacy.” Redacted information includes names and email addresses of White House employees with security clearances, as well as Redacted information includes names, identities, email addresses, and VA usernames of VA law enforcement employees. The

release of this information would risk impersonation of these White House employees with security clearances also working on national security and law enforcement matters, as well as jeopardizing their health and safety and those the White House employees are charged with protecting. The release of this information would risk impersonation of VA law enforcement personnel and jeopardize the health and safety of not only law enforcement personnel, but those persons the VA law enforcement personnel protect including the VA Secretary.

5 U.S.C. § 552(b)(7)(E) exempts from required disclosure information that “would disclose techniques and procedures for law enforcement investigations or prosecutions, or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law.” Redacted information includes VA usernames of VA law enforcement employees and shared VA email groups, for which VA law enforcement officials plan their law enforcement operations and protection of VA personnel. The release of this information would compromise the safety of VA law enforcement personnel and VA employees.

18-07426-F: 11/20/18, 2nd Partial IAD & Reasonable Searches Dated 5/8/18, 9/18/18, 10/12/18, 10/16/18, & 11/15/18

On October 12, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to June 22, 2018. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. These October 12, 2018, and October 16, 2018, searches yielded forty-four (44) pages, which the VA released redacted as pages Bates-numbered 243-286 on November 20, 2018.

On September 18, 2018, and October 16, 2018, the OSVA FOIA office searched through former VA Acting Chief of Staff Jacquelyn Hayes-Byrd's emails and calendars from November 8, 2016, to June 22, 2018. OSVA used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred fifty-five (255) pages, which OSVA released redacted as pages Bates-numbered 287-541 on November 20, 2018.

On October 18, 2018, the OSVA FOIA office searched through the email boxes and calendars, from January 20, 2017, to June 22, 2018, of: 1) Bowman, Thomas, former VA Deputy Secretary; 2) Wright-Simpson, Vivieca, former VA Chief of Staff; 3) Selnick, Darin, former VA White House Senior Advisor; 4) Lukach, Michael, former VA White House Senior Advisor; 5) Leinenkugel, Jake, former VA White House Senior Advisor; and 6) Spero, Casin D, former VA White House Liaison. The OSVA FOIA office used the search terms Sherman, Perlmutter, Moskowitz, @frenchangel59.com, and Kushner. This search yielded two hundred seventy-two (272) pages, which OSVA released redacted as pages Bates-numbered 542-813 on November 20, 2018.

On November 15, 2018, the OSVA FOIA office searched through the email boxes and calendars from June 23, 2018, to September 6, 2018, including of:

- 1) Wilkie, Robert L., Jr., VA Secretary;
- 2) O'Rourke, Peter M., former VA Acting Secretary;
- 3) Bowman, Thomas, former VA Deputy Secretary;
- 4) Hayes-Byrd, Jacquelyn, former VA Acting Chief of Staff;
- 5) Wright-Simpson, Vivieca, former VA Chief of Staff;
- 6) Selnick, Darin, former VA White House Senior Advisor;
- 7) Lukach, Michael, former VA White House Senior Advisor;
- 8) Leinenkugel, Jake, former VA White House Senior Advisor; and,

9) Spero, Casin D, former VA White House Liaison.

The November 15, 2018, search yielded two pages, which OSVA release redacted as pages Bates-numbered 814-815 on November 20, 2018.

Our May 8, 2018 (our search cut-off date) search yielded fifty-six (56) pages of email communication to or from Jared Kushner. On November 20, 2018, OSVA released these fifty-six (56) pages redacted as pages Bates-numbered 816-871.

After reviewing six hundred twenty-nine (629) pages Bates-numbered 243-871, OSVA redacted some information with FOIA Exemptions 4, 5, 6, and 7(C). Pages bates-numbered 872-995 are intentionally left blank.

18-07426-F: 9/14/18, Partial IAD & Reasonable Searches Dated 5/8/18

On May 8, 2018, our search cut-off date, we searched through former VA Secretary David Shulkin's emails and calendars from February 14, 2017 (the date he became VA Secretary), to March 30, 2018 (the date he left VA). We searched through VA Secretary Robert Wilkie's emails and calendars from April 1, 2018 (the date he became VA Acting Secretary) to May 8, 2018.

We searched through former VA Acting Secretary Peter O'Rourke's emails and calendars from February 15, 2018 (the date he became VA Acting Chief of Staff), to May 3, 2018. VA will conduct a follow-up search of former VA Acting Secretary Peter O'Rourke's emails and calendars from May 4, 2018, to May 8, 2018.

OSVA searched for any emails to or from Mr. Perlmutter, Dr. Moskowitz, and Mr. Kushner. Our search thus far yielded two hundred ninety-eight (298) pages, of which fifty-six (56) pages require consultation with the White House FOIA Liaison. After reviewing two hundred forty-two (242) pages, OSVA redacted some information with FOIA Exemptions 5, 6, 7(C), and 7(E). Bates-numbered as 1-242 on September 14, 2018.

FOIA Mediation

As part of the 2007 FOIA amendments, the Office of Government Information Services (OGIS) was created to offer mediation services to resolve disputes between FOIA requesters and Federal agencies as a non-exclusive alternative to litigation. Using OGIS services does not affect your right to pursue litigation. Under the provisions of the FOIA Improvement Act of 2016, the following contact information is provided to assist FOIA requesters in resolving disputes:

VA Central Office FOIA Public Liaison:

Name: John Buck

Email Address: vacofoiaservice@va.gov

Office of Government Information Services (OGIS)

Email Address: ogis@nara.gov

Fax: 202-741-5769

Mailing address:

National Archives and Records Administration

8601 Adelphi Road

College Park, MD 20740-6001

Mr. McGrath, Esq., & Mr. Evers
Page 9
August 24, 2019

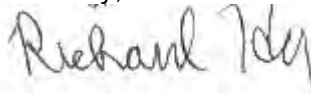
FOIA Appeal

This concludes OSVA's Seventh Partial IAD to request **18-11960-F**. Please be advised that should you desire to do so, you may appeal the determination made in this response to:

Office of General Counsel (024)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

If you should choose to file an appeal, please include a copy of this letter with your written appeal and clearly indicate the basis for your disagreement with the determination set forth in this response. Please be advised that in accordance with VA's implementing FOIA regulations at 38 C.F.R. § 1.559, your appeal must be postmarked no later than ninety (90) days of the date of this letter.

Sincerely,



Richard Ha, JD, CIPP/G
OSVA FOIA Officer

Attachment - Redacted pages Bates-numbered 5777-6672

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: Leinenkugel, Jake </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> O'Rourke, Peter M. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Davis, Lynda </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Wagner, John (Wolf) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Shelby, Peter J. </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)> Ulyot, John </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: (b) (6) visiting tomorrow
Date: Wed Aug 16 2017 16:02:21 CDT
Attachments: (b) (6) ES 0617.pdf

All-

A few of you met (b) (6) several weeks ago, I'm attaching his resume here. He's currently at DOD and PPO is hoping we can find a place for him at VA. He's coming in again tomorrow afternoon to meet with Brooks at 3pm, but if anyone is available to sit down with him I'm happy to facilitate.

Thanks,

(b) (6)

--

(b) (6)

White House Liaison

Department of Veterans Affairs

202-461-(b) (6) office

202-817-(b) (6) cell

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6)
Filename: (b) (6) ES 0617.pdf
Last Modified: Wed Aug 16 15:02:21 CDT 2017

(b) (6)

(b) (6) YAHOO.COM

CELL-(703)624-(b) (6)

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PROFESSIONAL EXPERIENCE
EXECUTIVE SUMMARY

OFFICE OF THE SECRETARY OF DEFENSE

THE PENTAGON

January 2017 to Present

Director of Travel Operations: (b) (6), (b) (2)

58TH PRESIDENTIAL INAUGURAL COMMITTEE

WASHINGTON, DC

December 2016 to Present

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NEW YORK, NY

June to November 2016

Advance Lead: (b) (6), (b) (2)

Promotion: Promoted from Press Lead to Advance Lead in October, 2016.

(b) (6) & COMPANY

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June 2015 to June 2016

Principal: (b) (6), (b) (2)

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ARLINGTON, VA

June 2014 to June 2015

Director of Communications: (b) (6), (b) (2)

BURSON-MARSTELLER

WASHINGTON, DC

October 2013 to March 2014

Director, Public Affairs & Crisis Practice: (b) (6), (b) (2)

BGR GROUP

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July 2009 to September 2013

Vice President of Public Relations: (b) (6), (b) (2)

OFFICE OF COMMUNICATIONS

THE WHITE HOUSE

EXECUTIVE OFFICE OF THE PRESIDENT

March 2008 to January 2009

(b) (6), (b) (2)

- PAGE 2 OF 2

Director of Outreach: (b) (6), (b) (2)OFFICE OF THE UNDER SECRETARY OF COMMERCE

WASHINGTON, DC

BUREAU OF INDUSTRY AND SECURITY (BIS), DEPARTMENT OF COMMERCE

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Deputy Chief of Staff and Senior Advisor: (b) (6), (b) (2)OFFICE OF THE SECRETARY OF DEFENSE

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DALLAS, TEXAS

April 2013

Media Liaison: (b) (6), (b) (2)2012 REPUBLICAN NATIONAL CONVENTION

TAMPA, FLORIDA

July to August 2012

Swing State Captain: (b) (6), (b) (2)GEORGE W. BUSH FOR PRESIDENT

NORTHERN VIRGINIA

September 1999 to February 2001

Advance Team Volunteer: (b) (6), (b) (2)EDUCATIONJAMES MADISON UNIVERSITY

HARRISONBURG, VIRGINIA

DEGREE: Bachelor of Science - May, 1994 (with Honors)

MAJOR / MINOR: Political Science / Communications

EXPANDED VERSION DETAILING PROFESSIONAL ACCOMPLISHMENTS AVAILABLE UPON REQUESTEXPERIENCE PRIOR TO 2002 IN LOBBYING, GRASSROOTS ORGANIZING AND ON CAPITOL HILL
AVAILABLE UPON REQUESTREFERENCES AVAILABLE UPON REQUESTPERSONAL**ADDRESS:**

(b) (6) JR.

(b) (6), (b) (2)

ALEXANDRIA, VIRGINIA (b) (6), (b) (2)

DATE OF BIRTH (AGE): (b) (6), (b) (2)**FAMILY:**

(b) (6), (b) (2)

From: (b) (6) <(b) (6)@yahoo.com>
To: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Thank you
Date: Mon Aug 14 2017 17:40:28 CDT
Attachments: ATT00001.htm
(b) (6) ES 0617.pdf

Owner: (b) (6) <(b) (6)@yahoo.com>
Filename: ATT00001.htm
Last Modified: Mon Aug 14 16:40:28 CDT 2017

Here you go. Thanks.

(b) (6) Jr.
(703)624-(b) (6), (b) (2) - Direct

On Aug 14, 2017, at 3:24 PM, (b) (6) <(b) (6), (b) (2)@va.gov> wrote:

Can you resend your resume? I know I had it, but my email's lately not letting me search.

--
(b) (6)
White House Liaison
Department of Veterans Affairs
202-461-(b) (6) office
202-817-(b) (6) cell

From: (b) (6) [mailto:(b) (6)@yahoo.com]
Sent: Friday, August 11, 2017 3:06 PM
To: (b) (6)
Subject: Re: [EXTERNAL] Thank you

Thanks (b) (6) Look forward to hearing back once you two connect.

(b) (6) Jr.
(703)624-(b) (6), (b) (2) - Direct
On Aug 11, 2017, at 2:59 PM, (b) (6) <(b) (6), (b) (2)@va.gov> wrote:

(b) (6), (b) (2)

Sorry I missed your call yesterday, been running around getting folks sworn in (2 new Asst Secs and our GC). I've got to get with Jake when he's back next week, but you're still on our radar. Don't hesitate to reach out..

(b) (6)

--
(b) (6)
White House Liaison
Department of Veterans Affairs
202-461-(b) (6) office
202-817-(b) (6) cell

From: (b) (6) [mailto:(b) (6)@yahoo.com]
Sent: Wednesday, July 26, 2017 11:01 AM
To: Leinenkugel, Jake
Cc: (b) (6)
Subject: [EXTERNAL] Thank you

Jake and (b) (6)

Thank you both for taking the time to meet with me late last week. I very much enjoyed our conversation as well as having the opportunity to talk with the other members of the political team.

I appreciated the candor in our conversation about the challenges -- and opportunities -- you are

facing at the Department of Veterans Affairs. I am excited about the prospect of joining your team to help navigate -- and make the most -- of them.

I look forward to continuing the conversation and remain available to talk by phone or meet again in person at your convenience.

Very Respectfully,

(b) (6) Jr.
(703)624-(b) (6), (b) (2) - cell

Owner: (b) (6) <(b) (6) yahoo.com>
Filename: (b) (6) ES 0617.pdf
Last Modified: Mon Aug 14 16:40:28 CDT 2017

(b) (6)

(b) (6) [YAHOO.COM](mailto:(b) (6)@YAHOO.COM)

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DALLAS, TEXAS

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DATE OF BIRTH (AGE): (b) (6), (b) (2)**FAMILY:**

(b) (6), (b) (2)

From: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
To: Tucker, Brooks </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Cc:
Bcc:
Subject: (b) (6)
Date: Mon Aug 14 2017 15:30:01 CDT
Attachments: (b) (6).pdf

Did you meet him a few weeks back? Trying to find a spot for him here if possible.

--

(b) (6)

White House Liaison

Department of Veterans Affairs

202-461-(b) (6) office

202-817-(b) (6) cell

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6)
Filename: (b) (6).pdf
Last Modified: Mon Aug 14 14:30:01 CDT 2017

(b) (6) [REDACTED], JR.

(b) (6) [YAHOO.COM](mailto:[REDACTED]@YAHOO.COM)

CELL-(703)624-(b) (6)

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(b) (6) & COMPANY

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June 2014 to June 2015

Director of Communications: (b) (6), (b) (2)

BURSON-MARSTELLER

WASHINGTON, DC

October 2013 to March 2014

Director, Public Affairs & Crisis Practice: (b) (6), (b) (2)

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OFFICE OF THE SECRETARY OF DEFENSE

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Commendation: Secretary of Defense Medal for Outstanding Public Service, December, 2006

VOLUNTEER EXPERIENCE

DEDICATION OF GEORGE W. BUSH PRESIDENTIAL LIBRARY

DALLAS, TEXAS

April 2013

Media Liaison: (b) (6), (b) (2)

2012 REPUBLICAN NATIONAL CONVENTION

TAMPA, FLORIDA

July to August 2012

Swing State Captain: (b) (6), (b) (2)

GEORGE W. BUSH FOR PRESIDENT

NORTHERN VIRGINIA

September 1999 to February 2001

Advance Team Volunteer: (b) (6), (b) (2)

SECURITY CLEARANCE LEVEL

TOP SECRET / Sensitive Compartmentalized Information (TS-SCI) – Inactive, but renewable.

EDUCATION

JAMES MADISON UNIVERSITY

HARRISONBURG, VIRGINIA

DEGREE: Bachelor of Science – May, 1994 (with Honors)

MAJOR / MINOR: Political Science / Communications

EXPANDED VERSION DETAILING PROFESSIONAL ACCOMPLISHMENTS AVAILABLE UPON REQUEST

EXPERIENCE PRIOR TO 2002 IN LOBBYING, GRASSROOTS ORGANIZING AND ON CAPITOL HILL
AVAILABLE UPON REQUEST

REFERENCES AVAILABLE UPON REQUEST

PERSONAL

ADDRESS: (b) (6) JR.

(b) (6), (b) (2)

ALEXANDRIA, VIRGINIA (b) (6), (b) (2)

DATE OF BIRTH (AGE): (b) (6), (b) (2)

FAMILY: (b) (6), (b) (2)

From: Shulkin, David J., MD
<david.shulkin@va.gov>
To: (b) (6) <(b) (6)@va.gov>
Cc:
Bcc:
Subject: FW: Concerned veteran
Date: Sun Aug 13 2017 14:10:59 CDT
Attachments:

From: (b) (6) SMTP: (b) (6)@HOTMAIL.COM]
Sent: Sunday, August 13, 2017 2:10:22 PM
To: Shulkin, David J., MD
Subject: [EXTERNAL] Concerned veteran
Auto forwarded by a Rule

I've been a RN for 46 years, 10 1/2 years active duty USAF and retired from the USN Reserves. I have been working at the Eugene VA for just over a year in the Surgical Specialty Clinic. January 2017, we were delighted to welcome Dr. (b) (6) to our staff. He worked part time for 7 months and came on full time July 23, 2017. Dr. (b) (6) is a retired USAF Colonel, USAF Academy graduate and deployed four times as combat surgeon. He retired in 2013 and settled in Oregon eventually becoming the Trauma Medical Director at Sacred Heart Riverbend. Dr. (b) (6) was the on-call trauma surgeon the tragic day Umpqua Community College suffered the active shooter event. He left his civilian practice because he wanted to make a difference and help our veterans.

Dr. (b) (6) was a "breath of fresh air" for our clinic. He wanted to increase the number of patients we were seeing, upgrade the surgical side to include laparoscopic procedures, and basically give the veterans the best care we could provide. July 31, 2017, Dr. (b) (6) (non-board certified) and his crony Dr. (b) (6) from the Roseburg VA suspended him. Tuesday the 2nd he was reinstated in a different capacity and that Friday, August 4, 2017 he was fired. This is a continuing practice of (b) (6) and (b) (6) they have made a habit of forcing other highly qualified physicians out. Dr. (b) (6) was denied due process.

Over 15 nurses are standing in full support with Dr. (b) (6) are fighting back with letters, e-mails and trying to get newspaper and television coverage. We want to get the word out to the military community, those that Dr. (b) (6) has cared for, his peers and anyone that will help fight this injustice. This not only affects Dr. (b) (6) but all the veterans that get their care in the Roseburg VA System. This not only affects the general surgery clinic, but other specialty care fee provider physicians are pulling out because they are afraid they might be targeted.

From: (b) (6) <(b) (6) hotmail.com>
To: Shulkin, David J., MD
</o=va/ou=exchange administrative group
(fydibohf23spdlt)/cn=recipients/cn=vacoshulkd>
Cc:
Bcc:
Subject: [EXTERNAL] Concerned veteran
Date: Sun Aug 13 2017 14:10:22 CDT
Attachments:

I've been a RN for 46 years, 10 1/2 years active duty USAF and retired from the USN Reserves. I have been working at the Eugene VA for just over a year in the Surgical Specialty Clinic. January 2017, we were delighted to welcome Dr. (b) (6) to our staff. He worked part time for 7 months and came on full time July 23, 2017. Dr. (b) (6) is a retired USAF Colonel, USAF Academy graduate and deployed four times as combat surgeon. He retired in 2013 and settled in Oregon eventually becoming the Trauma Medical Director at Sacred Heart Riverbend. Dr. (b) (6) was the on-call trauma surgeon the tragic day Umpqua Community College suffered the active shooter event. He left his civilian practice because he wanted to make a difference and help our veterans.

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From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:59:38 CDT
Attachments:

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:55 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:51 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Yes, I can do that.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

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I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6) shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
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Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

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Not good, flying to Texas to give a speech. Morning of 31st looks good.

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From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

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Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (2)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:(b) (6)@gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6)@gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6), (b) (2) <(b) (6)> shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)> gmail.com> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6), (b) (2) <(b) (6)> shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there? Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6) gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6) gmail.com> wrote:

(b) (6), (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6) cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 2:54 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)

bouldercrestretreat.org

www.bouldercrestretreat.org

520.631

(b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)@cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:54:42 CDT
Attachments:

Invite sent. See you then. thanks and have a great day. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Date: Thursday, August 10, 2017 at 5:51 PM
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To: Selnick, Darin
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(b) (6), (b) (2)

(571) 344-[REDACTED] Cell

www.shoulder2shoulderinc.com

Twitter@[REDACTED]

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From: "Selnick, Darin" <[REDACTED]@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: [REDACTED] <[REDACTED]@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: [REDACTED] (b) (6), (b) (2) [mailto:[REDACTED]@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

[REDACTED] (b) (6), (b) (2)

(571) 344-[REDACTED] Cell

www.shoulder2shoulderinc.com

Twitter@[REDACTED]

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Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

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To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

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(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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Best

Darin

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Twitter@[REDACTED]

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From: "Selnick, Darin" <[REDACTED]@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: [REDACTED] <[REDACTED]@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi [REDACTED]

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:[REDACTED]@gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin

Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)@gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

Shoulder 2 Shoulder, Inc

(571) 344- (b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6) gmail.com> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

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Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

(b) (6), (b) (2)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

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From: Darin Selnick <(b) (6) gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)@gmail.com> wrote:

(b) (6), (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

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On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)@cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting

experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631-(b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6) cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631-(b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6) cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:[REDACTED]@cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: [REDACTED] <[REDACTED]@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, [REDACTED] <[REDACTED]@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:51:28 CDT
Attachments:

Yes, I can do that.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:36 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Could you do lunch on the 5th?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6) va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6) shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

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(b) (6), (b) (2)

(571) 344-(b) (6) Cell

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(571) 344- (b) (6)

Twitter@ (b) (6)

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(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

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(b) (6)

Member of the Board of Directors

(b) (6)@bouldercrestretreat.org

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520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6)@cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:36:03 CDT
Attachments:

Could you do lunch on the 5th?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:34 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Sure

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6), (b) (2)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6) va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6) shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6), (b) (2)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6) va.gov>

Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:(b) (6)@gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6)@gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6)@gmail.com> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there? Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6) gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6) gmail.com> wrote:

(b) (6), (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6) cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

Confidentiality:

The information contained in, and attached to, this communication may be confidential, and is intended only for the use of the recipient named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. If you have received this communication in error, please re-send this communication to the sender and delete the original message and any copy of it from your computer system. Thank you.

From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

Confidentiality:

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 2:54 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

Confidentiality:

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6) bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:34:24 CDT
Attachments:

Sure

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:32 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Should we look at dates after labor Day?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

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Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

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(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6) shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (2)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Hi (b) (6)

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Best

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Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (2)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6) va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:(b) (6) gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6)@gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6) gmail.com> wrote:

Hi (b) (6)

That works. Government rules say I have to pay for my own lunch.

Darin

On Sun, Jul 23, 2017 at 3:24 AM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there? Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6) gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

Shoulder 2 Shoulder, Inc

(571) 344- (b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6) gmail.com> wrote:

(b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6) cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6)@bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:31:46 CDT
Attachments:

Should we look at dates after labor Day?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:19 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6), (b) (2)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6) va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6) shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6), (b) (2)

(571) 344- (b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6) va.gov>

Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:(b) (6)@gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

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From: Darin Selnick <(b) (6) gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

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Sent from my iPhone

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(b) (6), (b) (2)

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From: Darin Selnick <(b) (6) gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

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Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

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(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

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Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)
Boulder Crest Retreat
520.631 (b) (6)

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To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell
Concerned Veterans for America
C: [602] 999- (b) (6)

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

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Subject: Re: Follow Up Meeting

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Thanks again looking forward to catching up.

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Boulder Crest Retreat

520.631 (b) (6)

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Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6)@bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

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Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:19:09 CDT
Attachments:

I am in town but I am leaving to go to the airport at 2pm, so it would have to be before then.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:16 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

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(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

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Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

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(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:(b) (6)@gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Let me check.

Thanks

Darin

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Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

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From: Darin Selnick <(b) (6)> gmail.com>

Date: Saturday, July 22, 2017 at 6:40 PM

To: (b) (6) <(b) (6)> shoulder2shoulderinc.com>

Cc: (b) (6) <(b) (6)> bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6), (b) (2) <(b) (6)> shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)> gmail.com> wrote:

(b) (6), (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)> cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 2:54 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6) cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]
Sent: Thursday, July 13, 2017 5:18 PM
To: (b) (6) <(b) (6) bouldercrestretreat.org>
Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

Sent from my iPhone

On Jul 13, 2017, at 7:27 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
To: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdl)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:15:46 CDT
Attachments:

Are you in town that day? I have an 1130 funeral that day at Arlington and could be in DC that afternoon.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:12 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6) shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

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I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

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Sent: Thursday, August 10, 2017 9:51 AM
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Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@[REDACTED]

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <[REDACTED]va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: [REDACTED] <[REDACTED]shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi [REDACTED]

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

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To: Selnick, Darin
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Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. [REDACTED] (b) (6)

[REDACTED] (b) (2)

(571) 344-[REDACTED] (b) (6) Cell

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Twitter@[REDACTED] (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
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Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

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Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

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Sent from my iPhone

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Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

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(b) (6), (b) (2)

(571) 344-(b) (6) Cell

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Twitter@ (b) (6)

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(571) 344-(b) (6)

Twitter@ (b) (6)

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To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

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(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

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(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

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Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

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Dan Caldwell

Concerned Veterans for America

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(b) (6)

Boulder Crest Retreat

520.631- (b) (6)

----- Original message -----

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Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

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Dan,

No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:12:01 CDT
Attachments:

Not good, flying to Texas to give a speech. Morning of 31st looks good.

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 5:10 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

How does the morning of the 29th look?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 5:08 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
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Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

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To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

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Thanks

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

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From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
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Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:(b) (6) gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6) gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6) gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

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Sent from my iPhone

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Hi (b) (6)

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From: Darin Selnick <(b) (6)@gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

Shoulder 2 Shoulder, Inc

(571) 344- (b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6)@gmail.com> wrote:

(b) (6), (b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6) cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6) cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 2:54 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Hi Dan, sorry to go back and forth on this but wondering if you can do lunch around 1215 at the CHC. A bit earlier but our 1230 got moved to 1330.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

C: [602] 999 (b) (6)

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Thanks again looking forward to catching up.

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Member of the Board of Directors

(b) (6)

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To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:09:38 CDT
Attachments:

How does the morning of the 29th look?

(b) (6), (b) (2)

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www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

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From: Darin Selnick <(b) (6)> gmail.com>

Date: Saturday, July 22, 2017 at 6:40 PM

To: (b) (6) <(b) (6)> shoulder2shoulderinc.com>

Cc: (b) (6) <(b) (6)> bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

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Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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Boulder Crest Retreat

520.631 (b) (6)

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From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

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Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

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<image002.jpg>

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No worries. For some reason, I was having some other email issues and wanted to make sure I followed up.

Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 17:08:04 CDT
Attachments:

Hi (b) (6)

Just got back to my desk, can talk for a few minutes now or we can set up a longer call for after your Arizona trip.

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 4:24 PM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Sorry I keep missing you. Back at my desk now. Would this work. Otherwise, I am in Arizona next week and the week after that would be best. Thanks. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Thursday, August 10, 2017 at 10:56 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

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Hi (b) (6)

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From: "Selnick, Darin" <(b) (6)@va.gov>

Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:(b) (6)@gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6) gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

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(571) 344-(b) (6)

Twitter@ (b) (6)

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Sent from my iPhone

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Hi (b) (6)

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Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
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From: Darin Selnick <(b) (6)@gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

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Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-[REDACTED]

Twitter@[REDACTED]

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <[REDACTED]@gmail.com> wrote:

[REDACTED] and [REDACTED]

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <[REDACTED]@cv4a.org> wrote:

[REDACTED] and [REDACTED]

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – [REDACTED] runs Boulder Crest Retreat for veterans and [REDACTED] on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

[REDACTED] and [REDACTED] let me know how else I can be helpful.

Thanks,

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Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 16:23:34 CDT
Attachments:

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(571) 344-(b) (6) Cell

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Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631- (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/19/17 2:55 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999-(b) (6)

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Boulder Crest Retreat

520.631 (b) (6)

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From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/17/17 12:50 PM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

That works.

Dan Caldwell

Concerned Veterans for America

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Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: Re: Follow Up Meeting

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Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

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Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 10:56:14 CDT
Attachments:

(b) (6)

I just got out of meetings. Free now or we can schedule for next week.

Thanks

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 9:51 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, a call sound great. Any chance you are free now?

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: "Selnick, Darin" <(b) (6)@va.gov>

Date: Thursday, August 10, 2017 at 9:40 AM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

Darin, Good morning. I am very sorry, but I didn't hear back from you on that last email and now my day is slammed. A friend of mine is getting buried in Arlington on August 31st and that's the next time I am in DC. Any chance we could meet later in the day on the 31st? Say 230-3ish? Very sorry for not following up. (b) (6)

(b) (2)

(571) 344-(b) (6) Cell

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From: "Selnick, Darin" <(b) (6)@va.gov>
Date: Wednesday, August 9, 2017 at 8:49 PM
To: (b) (6) <(b) (6)@shoulder2shoulderinc.com>
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

Hi (b) (6)

Checking to see if we are on for lunch tomorrow. If you are, can we meet earlier at 11:30am and can we meet in front of the Department of Veterans Affairs, 810 Vermont Ave, NW, DC.

Thanks

Darin

Darin Selnick

Senior Advisor to the Secretary

Cell 202-390-5845

From: Darin Selnick [mailto:(b) (6)@gmail.com]
Sent: Wednesday, August 09, 2017 8:42 PM
To: Selnick, Darin
Subject: [EXTERNAL] Fwd: Follow Up Meeting

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6)@gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-^{(b) (6)} Cell

www.shoulder2shoulderinc.com

Twitter@^{(b) (6)}

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From: Darin Selnick <^{(b) (6)}gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: ^{(b) (6)} <^{(b) (6)}shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

On Sun, Jul 23, 2017 at 5:50 AM, ^{(b) (6), (b) (2)} <^{(b) (6)}shoulder2shoulderinc.com> wrote:

Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

^{(b) (6), (b) (2)}

Shoulder 2 Shoulder, Inc

(571) 344-^{(b) (6)}

Twitter@^{(b) (6)}

www.shoulder2shoulderinc.com

Sent from my iPhone

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Hi ^{(b) (6)}

That works. Government rules say I have to pay for my own lunch.

Darin

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Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there?
Thanks.

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From: Darin Selnick <(b) (6) gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

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Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6)@cv4a.org> wrote:

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It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

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Dan Caldwell

Concerned Veterans for America

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Boulder Crest Retreat

520.631 (b) (6)

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Yes I can do 1215. Is the reservation under your membership?

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(b) (6)@bouldercrestretreat.org

www.bouldercrestretreat.org

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To: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdl)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 09:51:14 CDT
Attachments:

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(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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Cc: (b) (6) <(b) (6)> bouldercrestretreat.org>

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Concerned Veterans for America

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Subject: RE: Follow Up Meeting

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Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6) bouldercrestretreat.org]

Sent: Monday, July 17, 2017 12:33 PM

To: Dan Caldwell <(b) (6) cv4a.org>

Subject: Re: Follow Up Meeting

Dan,

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Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

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Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

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To: (b) (6), (b) (2) <(b) (6)@shoulder2shoulderinc.com>
Cc:
Bcc:
Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting
Date: Thu Aug 10 2017 09:40:59 CDT
Attachments:

Hi (b) (6)

No problem. I will be out of town that day, but how about setting up a phone call for some time next week.

Best

Darin

From: (b) (6), (b) (2) [mailto:(b) (6)@shoulder2shoulderinc.com]
Sent: Thursday, August 10, 2017 7:22 AM
To: Selnick, Darin
Subject: Re: [EXTERNAL] Fwd: Follow Up Meeting

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Subject: RE: [EXTERNAL] Fwd: Follow Up Meeting

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Cell 202-390-5845

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Subject: Re: Follow Up Meeting

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Boulder Crest Retreat

520.631- (b) (6)

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Date: Thu Aug 10 2017 07:21:51 CDT
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Darin, thank you for this. If we do the met, you'll have to pay me, unless you are a member. Otherwise happy to go anywhere else. Your call. Thx!

(b) (6), (b) (2)

Shoulder 2 Shoulder, Inc

(571) 344-(b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 23, 2017, at 8:43 AM, Darin Selnick <(b) (6) gmail.com> wrote:

Hi (b) (6)

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Darin

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Darin, How about lunch on the 10th? I am a member at the Met Club and happy to host you there? Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive veterans of early wars were treated and appreciated by our nation." - George Washington

"We make a living by what we get. We make a life by what we give." - Sir Winston Churchill

From: Darin Selnick <(b) (6) gmail.com>
Date: Saturday, July 22, 2017 at 6:40 PM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Cc: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

August 10 or 11 works, but would have to meet in DC.

Darin

On Sat, Jul 22, 2017 at 3:13 PM, (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com> wrote:

Dan, thank you and look forward to showing you AZ soon.

Darin, I am in Texas early this week and then off for a week. How does 10 or 11 August look for you. Any chance I can host you here in Bluemont? We are an hour west of D.C. If not, happy to meet in town. Thank you! (b) (6)

(b) (2)

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(571) 344- (b) (6)

Twitter@ (b) (6)

www.shoulder2shoulderinc.com

Sent from my iPhone

On Jul 22, 2017, at 4:38 PM, Darin Selnick <(b) (6) gmail.com> wrote:

(b) (6) and (b) (6)

Great to meet you. Happy to discuss the future of VA care and your VA experiences.

Best

Darin

On Thu, Jul 20, 2017 at 12:27 PM, Dan Caldwell <(b) (6) cv4a.org> wrote:

(b) (6) and (b) (6)

It was good to meet with you today.

I wanted to digitally introduce you both to Darin Selnick – who is currently Senior Advisor to Secretary Shulkin at the VA. Darin was previously CVA's Senior Advisor and really helped grow and focus our organization.

Darin – (b) (6) runs Boulder Crest Retreat for veterans and (b) (6) on their board and also is someone who has done a lot of political and advocacy in Arizona. Both are good contacts to have and they are both very interested in the future of VA care in the community. They also have had some interesting experiences engaging with the VA that I think might be worth you hearing.

(b) (6) and (b) (6) let me know how else I can be helpful.

Thanks,

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Wednesday, July 19, 2017 3:06 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: RE: Follow Up Meeting

Great see u then.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/19/17 2:55 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>
Subject: RE: Follow Up Meeting

Yes I can do 1215. Is the reservation under your membership?

Dan Caldwell

Concerned Veterans for America

C: [602] 999- (b) (6)

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Subject: RE: Follow Up Meeting

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Boulder Crest Retreat

520.631- (b) (6)

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From: Dan Caldwell <(b) (6)@cv4a.org>
Date: 7/17/17 12:50 PM (GMT-05:00)
To: (b) (6) <(b) (6)@bouldercrestretreat.org>

Subject: RE: Follow Up Meeting

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Dan Caldwell

Concerned Veterans for America

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From: (b) (6) [mailto:(b) (6)@bouldercrestretreat.org]
Sent: Monday, July 17, 2017 12:33 PM
To: Dan Caldwell <(b) (6)@cv4a.org>
Subject: Re: Follow Up Meeting

Dan,

Sorry for the late reply. We had a quick appt come in on the Hill for around that time... only 15 mins. How about 1pm at the CHC downstairs in the grill?

Thanks again looking forward to catching up.

(b) (6)

Boulder Crest Retreat

520.631 (b) (6)

----- Original message -----

From: Dan Caldwell <(b) (6) cv4a.org>

Date: 7/16/17 9:39 AM (GMT-05:00)

To: (b) (6) <(b) (6) bouldercrestretreat.org>

Subject: Re: Follow Up Meeting

Name the place and I will be there. Does 1230 work?

Sent from my iPhone

On Jul 15, 2017, at 10:20 PM, (b) (6) <(b) (6) bouldercrestretreat.org> wrote:

Dan,

Thanks for getting back to me and hope you're having a great weekend. How does Thursday for lunch sound – Cap Hill Club or something near the Hill?

Thanks again for your time.

(b) (6)

Member of the Board of Directors

(b) (6) bouldercrestretreat.org

www.bouldercrestretreat.org

520.631 (b) (6)

<image002.jpg>

From: Dan Caldwell [mailto:(b) (6) cv4a.org]

Sent: Thursday, July 13, 2017 5:18 PM

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Subject: Re: Follow Up Meeting

Wednesday the 19th before 3 pm is good and Thursday after 11 am is good as well. On Thursday I will be down town and can meet somewhere there

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Please let me know what times might be appropriate for the 19th or 20th. Thanks again and for your interest and support of BCR.

From: Darin Selnick <(b) (6) gmail.com>
To: Selnick, Darin </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Fwd: Follow Up Meeting
Date: Wed Aug 09 2017 20:42:28 CDT
Attachments:

Sent from my iPhone

Begin forwarded message:

From: (b) (6), (b) (2) <(b) (6) shoulder2shoulderinc.com>
Date: July 23, 2017 at 11:45:31 AM EDT
To: Darin Selnick <(b) (6) gmail.com>
Subject: Re: Follow Up Meeting

Standing by. Thanks.

(b) (6), (b) (2)

(571) 344-(b) (6) Cell

www.shoulder2shoulderinc.com

Twitter@ (b) (6)

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From: Darin Selnick <(b) (6) gmail.com>
Date: Sunday, July 23, 2017 at 8:52 AM
To: (b) (6) <(b) (6) shoulder2shoulderinc.com>
Subject: Re: Follow Up Meeting

Let me check.

Thanks

Darin

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From: (b) (6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b) (6)>
To: Schlichting, Nancy <ns@hfhs.org>;
lucetiamc@gmail.com <lucetiamc@gmail.com>; Stewart Hickey
(panzrldr6@hotmail.com) <panzrldr6@hotmail.com>; Selnick, Darin
</o=va/ou=exchange administrative group
(fydibohf23spdl)/cn=recipients/cn=(b) (6)>
mrsteele46@aol.com <mrsteele46@aol.com>; Johnson, Joyce
</o=va/ou=first administrative
group/cn=recipients/cn=(b) (6)> tomharveynyc@me.com
<tomharveynyc@me.com>; mblecker@stp-sf.org
<mblecker@stp-sf.org>; blomd@ohiohealth.com
<blomd@ohiohealth.com>; cosgrod@ccf.org <cosgrod@ccf.org>;
dgorman@dvamail.org <dgorman@dvamail.org>; athens5@aol.com
<athens5@aol.com>; Phil <philliplongman@gmail.com>; Charlene
Taylor <jackandcharlene@frontier.com>; 'Webster, Marshall'
(webstermw@upmc.edu) <webstermw@upmc.edu>
Cc: Moyer, Yvonne <ymoyer1@hfhs.org>;
mmoran@stp-sf.org <mmoran@stp-sf.org>; jane.ely@ohiohealth.com
<jane.ely@ohiohealth.com>; darcan@accf.org <darcan@accf.org>;
rruizapo@gmail.com <rruizapo@gmail.com>; epfcl@UPMC.EDU
<epfcl@upmc.edu>
Bcc:
Subject: Update Commission on Care Contact List
Date: Wed Aug 09 2017 11:33:19 CDT
Attachments: Commission on Care Commissioner Contact Information 08092017.docx

Greetings former Commissioners!

It's been just over a year since the Commission on Care Final Report was submitted! It was surely a pleasure to see those of you who could make it to Washington, DC for the Commission on Care Update held last week. Those who didn't make it were missed.

I have been asked by the VA Chief of Staff to provide an updated list of email addresses, mailing addresses and phone numbers. I am using a list that is over a year old and want to make sure I have the latest available information. If your contact information has changed from what was used while on the Commission on Care please send me an update as soon as possible. I've attached the information we currently have to make it easier.

I hope you are all doing well and hope that our paths will cross at a future date. Thank you.

Very respectfully,

(b) (6)

Executive Assistant to the Senior Advisor to the Secretary

Office of the Secretary

Department of Veterans Affairs

(b) (6)

va.gov

202-632- (b) (6) (office) # (b) (6)

202-714- (b) (6) (cell)

Owner:	(b) (6)	</o=va/ou=va martinsburg/cn=recipients/cn=(b) (6)
Filename:	Commission on Care Commissioner Contact Information 08092017.docx	
Last Modified:	Wed Aug 09 10:33:19 CDT 2017	

Commission on Care Commissioners Contact Information
Current as of August 9, 2017

	CoC Member	Title/ Organization	Assistant	Member Telephone	Member e-mail Address	Mailing Address	Attending?
1	BLECKER, Michael A.	Swords to Plowshares	Name: Mary Moran Title: Phone: 415-252-4788 Email: mmoran@stp-sf.org	415-823-0363	mblecker@stp-sf.org	Swords to Plowshares 1060 Howard St San Francisco, CA 94103	
2	BLOM, David P.	Ohio Health	Name: Jane Ely Title: Executive Assistant Phone: 614-544-4410 Email: Jane.Ely@ohiohealth.com	614-544-4412	blomd@ohiohealth.com	6433 Sunbury Drive Westerville, OH 43082	
3	COSGROVE, Delos "Toby"	Cleveland Clinic	Name: Claudia D'Arcangelo Title: Executive Assistant Phone: 216-444-1144 Email: darcan@accf.org	216-444-6733	cosgrod@ccf.org	Cleveland Clinic 9500 Euclid Ave, NA-4 Cleveland, OH 44195	
4	GORMAN, David W.	Disabled American Veterans	Name: No Assistant Title: Phone: Email:	301-651-7223	dgorman@davmail.org	312 Portabello Way Simpsonville, SC 29681	
5	HARVEY, Thomas E.		Name: No Assistant Title: Phone: Email:	646-352-2441	tomharveynyc@me.com	941 Park Ave #15C New, NY 10028	
6	HICKEY, Stewart M.	AMVETS	Name: Dave Gaif Title: Phone: 301-683-4035 Email:	301-683-4004	Panzrldr6@hotmail.com	104 Cold Spring Dr. McConnellsburg, PA 17233	
7	JOHNSON, Joyce M.	Retired USPHS Admiral	Name: No Assistant Title: Phone: Email:	301-986-7985	RADMJJohnson@gmail.com	5518 Western Ave Chevy Chase, MD 20815	yes
8	KHAN, Ikram U.	Quality Care Consultants	Name: Romina Ruiz Lynn	702-595-1059	Athens5@aol.com	Quality Care Consultants 3006 S. Maryland Pkwy	yes

Commission on Care Commissioners Contact Information
Current as of August 9, 2017

			Title Admin. Assistant Phone: 702-731-5003 Email: rruizapo@gmail.com			Suite 465 Las Vegas, NV 89109	
9	LONGMAN, Phillip J.	New America	Name: No Assitant Title: Phone: Email:	202-747-4079	philliplongman@gmail.com	3316 Northampton St, NW Washington, DC 20015	
10	McCLENNEY Lucretia		Name: Title: Phone: Email:	H: 540-972-7460 C: 703-915-6446 W: 703-697-4964	lucretiamc@gmail.com	12019 Fawn Lake Pkwy Spotsylvania, VA 22551	
11	SCHLICHTING, Nancy M.	Henry Ford Health System	Name: Yvonne Moyer Title: Sr. Executive Assistant Phone: (313) 876-8404 Email: ymoyer1@hfhs.org	248-723-2835	ns@hfhs.org	1710 Orchard Ln. Bloomfield, MI 48301	yes
12	SELNICK, Darin S.	Concerned Veterans for America	Name: No Assistant Title: Phone: Email:	571-345-6003	(b) (6) [REDACTED]@gmail.com	420 Shadow Tree Dr. Oceanside, CA 92058	
13	STEELE, Martin R.	Retired 3-Star Marine Corps General Veterans Research, University of South Florida	Name: Eddie Aikins Title: Administrative Specialist Phone: (813) 974-9374 Email: eaikins@usf.edu	813-866-7767	Mrsteele46@aol.com	16331 Ashington Park Dr. Tampa, FL 33647	yes
14	TAYLOR Charlene	Kaiser	Name: No Assistant Title: Phone:	C: 916-600-6224 H: 916-683- [REDACTED]	jackandcharlene@frontier.com	9303 Edensbury Ct, ElkGrove, CA 95758	

Commission on Care Commissioners Contact Information
Current as of August 9, 2017

			Email:	4017			
15	WEBSTER, Marshall W.	University of Pittsburgh Medical Center	Name: Cheri Hepfl Title: Assistant Phone: 412-647-5944 Email: epfcl@UPMC.EDU	412-487-8674	webstermw@upmc.edu	4562 Nature Trail Dr . Allison Park, PA 15101	

From: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Cc:
Bcc:
Subject: RE: [EXTERNAL] Comment regarding (b) (6)
Date: Wed Aug 09 2017 08:24:11 CDT
Attachments: image001.jpg

Thanks.

(b) (6)

Press Secretary

Department of Veterans Affairs

202-461-

(b) (6) va.gov

@ (b) (6)

From: Selnick, Darin
Sent: Tuesday, August 08, 2017 8:38 PM
To: (b) (6)
Subject: RE: [EXTERNAL] Comment regarding (b) (6)

A Ron Thomas was on the transition team and was a political appointee during Bush. He has no connection to CVA. I never heard of the other guy (b) (6) not transition and not CVA.

Darin

Sent with Good (www.good.com)

-----Original Message-----

From: (b) (6)
Sent: Tuesday, August 08, 2017 07:33 PM Eastern Standard Time
To: Selnick, Darin
Subject: FW: FW: [EXTERNAL] Comment regarding (b) (6)

Please see below and attached. This guy is claiming that two VA employees that have had performance issues, (b) (6) and Ronald Thomas, were members of the Trump VA transition team. I'm pretty sure they were not, but figured I'd check with you. Let me know.

Thanks,

(b) (6)

Press Secretary

Department of Veterans Affairs

202-461-(b) (6)

(b) (6) va.gov

@(b) (6)

From: Ben Leonard [mailto:bleonard@revealnews.org]

Sent: Tuesday, August 08, 2017 4:26 PM

To: Hayes, Terrence

Subject: [EXTERNAL] Comment regarding (b) (6)

Hi Terrence,

My name is Ben Leonard and I'm with Reveal from the Center for Investigative Reporting.

I'm working on a story about Trump's VA transition team and some of the influence Concerned Veterans for America has had on it as well as former transition team staffers that misused government funds or were tied to the misuse of government funds. I will need to finish the story by Friday.

This is the IG report about (b) (6) that I was referencing: <https://www.va.gov/oig/pubs/VAOIG-11-04049-205.pdf>

Vance was found to have misused government funds and falsified employment records about his proposed removal from the DOI before coming to the VA. The IG recommended administrative action, but according to federalpay.org (<https://www.federalpay.org/employees/dean-for-va-learning-university>), (b) (6) his salary has continued to rise. So following this report, my question is: why does he continue to get rising pay every year? Was any sort of administration actually taken?

Thanks,

Ben

--

Ben Leonard

650.533.0186

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revealnews.org

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Ben Leonard

Intern

650.533.0186

Twitter: @Ben___Leonard

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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6)
Filename: image001.jpg
Last Modified: Wed Aug 09 07:24:11 CDT 2017

image001.jpg for Printed Item: 38 (
Attachment 1 of 1)
6025

AMERICAN
OVERSIGHT
8-0457-J-000248

From: (b) (6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
To: Selnick, Darin </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)
Cc:
Bcc:
Subject: FW: FW: [EXTERNAL] Comment regarding (b) (6)
Date: Tue Aug 08 2017 19:33:38 CDT
Attachments: image001.jpg
image003.jpg
VoiceMessage.wav

Please see below and attached. This guy is claiming that two VA employees that have had performance issues, (b) (6) and Ronald Thomas, were members of the Trump VA transition team. I'm pretty sure they were not, but figured I'd check with you. Let me know.

Thanks,

(b) (6)

Press Secretary

Department of Veterans Affairs

202-461-(b) (6)

(b) (6) va.gov

@(b) (6)

From: Ben Leonard [mailto:bleonard@revealnews.org]
Sent: Tuesday, August 08, 2017 4:26 PM
To: Hayes, Terrence
Subject: [EXTERNAL] Comment regarding (b) (6)

Hi Terrence,

My name is Ben Leonard and I'm with Reveal from the Center for Investigative Reporting.

I'm working on a story about Trump's VA transition team and some of the influence Concerned Veterans for America has had on it as well as former transition team staffers that misused government

funds or were tied to the misuse of government funds. I will need to finish the story by Friday.

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Thanks,

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Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b) (6)
Filename: image001.jpg
Last Modified: Tue Aug 08 18:33:38 CDT 2017

image001.jpg for Printed Item: 40 (
Attachment 1 of 3)
6030

AMERICAN
OVERSIGHT
8-0457-J-000253

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Filename: image003.jpg
Last Modified: Tue Aug 08 18:33:38 CDT 2017

image003.jpg for Printed Item: 40 (
Attachment 2 of 3)
6032

AMERICAN
OVERSIGHT
8-0457-J-000255

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Filename: VoiceMessage.wav
Last Modified: Tue Aug 08 18:33:38 CDT 2017

Could not print file content for:

Document ID: 0.7.1705.188868-000003

Attachment Name: VoiceMessage.wav

Locator: es:\pst*\va\ausdc\scw200\L\$\Collections\GCL 100093 FOIA - American Oversight v. VA\Batch 1 Online\Darin Selnick\Darin.Selnick@va.gov.pst:0000000005e6fb389b1c9a84eb4d504d47c90470044112700:0700d7cddd7e912e746a1ebc46639dbd9d75411bb6bf98ff4a8d2672db5337fc651f

Reason: It is an unsupported file type

From: (b) (6) <(b) (6)@yahoo.com>
To: O'Rourke, Peter M. </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: [EXTERNAL] Stripes
Date: Fri Aug 04 2017 12:44:23 CDT
Attachments:

<https://www.stripes.com/news/va-whistleblower-gets-job-in-trump-s-new-accountability-office-1.481509#.WYSjbIVICEe>

Good one as she used Grassley's statement along with CVA statement

Sent from my iPhone

(b) (6)

From: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
To: Syrek, Christopher D. (Chris) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Verschoor, Thayer </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b) (6)>
Cc:
Bcc:
Subject: reference items
Date: Fri Aug 04 2017 08:56:32 CDT
Attachments: va org chart.pdf
VA_Acronyms_Jan2017.pdf
VA_Functional_Organization_Manual_Version_4.pdf

Thayer and Chris,

A few items that may come in handy 1) an org chart (it's from January, so names are not up to date), 2) an acronym list, 3) the Functional Organization Manual (FOM) which details what all offices are supposed to handle.

(b) (6)

--

(b) (6)

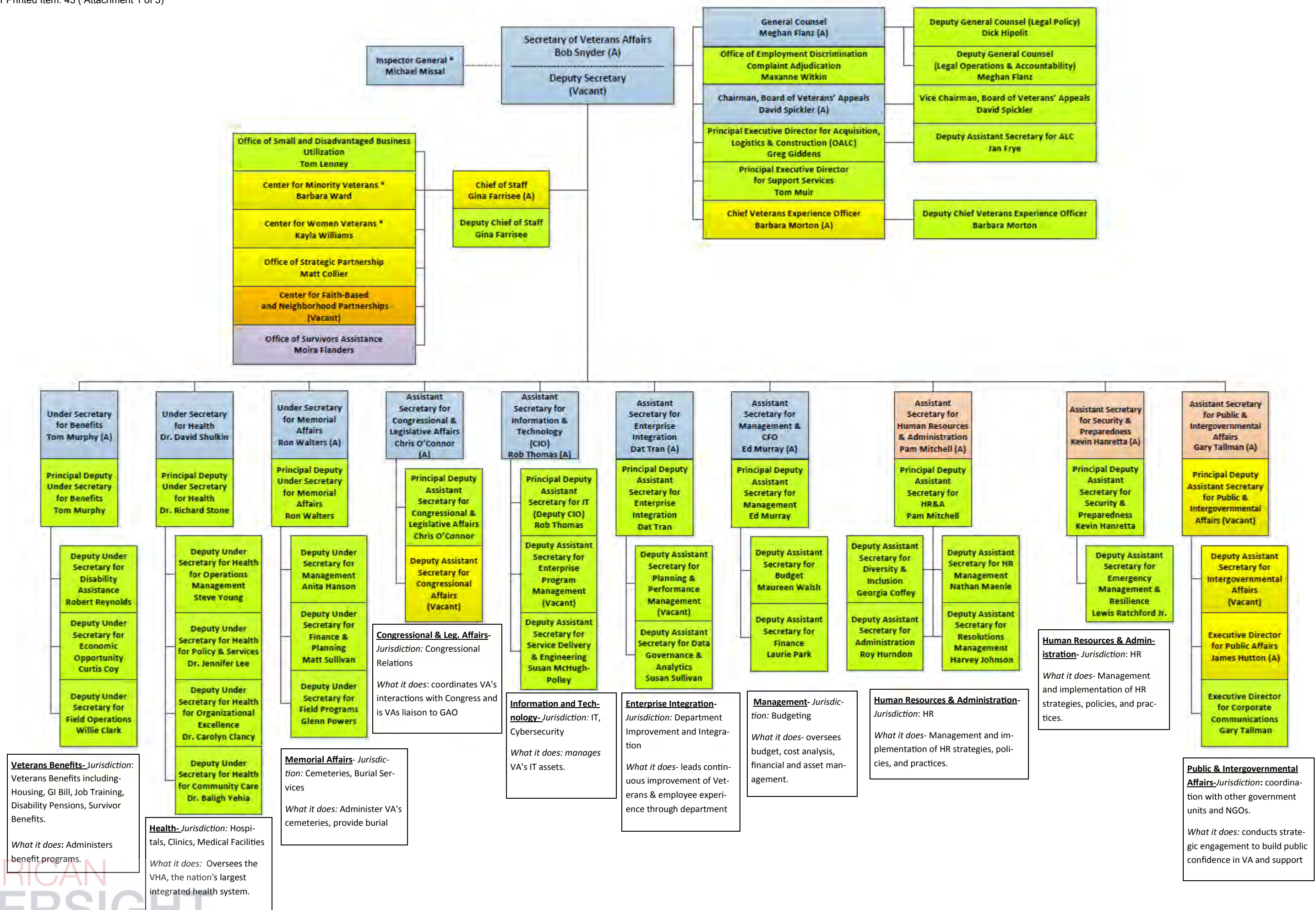
White House Liaison

Department of Veterans Affairs

202-461-(b) (6) office

202-817-(b) (6) cell

Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
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Filename: va org chart.pdf
Last Modified: Fri Aug 04 07:56:32 CDT 2017



Owner: (b) (6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
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Filename: VA_Acronyms_Jan2017.pdf
Last Modified: Fri Aug 04 07:56:32 CDT 2017

VA ACRONYM LOOKUP

Full List

Total Number of Acronyms in the Database: 5322

Can't find what you're looking for? [Suggest a new acronym!](#)

[A](#)[B](#)[C](#)[D](#)[E](#)[F](#)[G](#)[H](#)[I](#)[J](#)[K](#)[L](#)[M](#)[N](#)[O](#)[P](#)[Q](#)[R](#)[S](#)[T](#)[U](#)[V](#)[W](#)[X](#)[Y](#)[Z](#)

Acronym	Description	Date Updated
1		top
10-10 EZ	VA Form 10-10 EZ Application for Health Benefits	July 13, 2004
10N	Washington DC VACO	June 11, 2014
1U4N	1st letter last name + last 4 of SSN	November 22, 2005
2		top
2FA	2-Factor Authentication	April 17, 2014
3		top
3DES	Triple Data Encryption Standard	Added prior to March 2003
3GL	3rd Generation Language	July 26, 2004
3R	Recruitment, Retention and Relocation Allowances	February 04, 2010
4		top
4WW	Four Wheeled Walker	May 07, 2014
7		top
776	VHA CIO Administration System	November 08, 2005
A		top
A&A	Aid and Attendance	April 03, 2014
A&A	Advisory & Assistance	May 17, 2004
A&A	Assessment and Authorization	October 29, 2015
A&A LETTER	Aid & Attendance Letter	November 29, 2012
A&MM	Acquisition and Material Management	July 13, 2004
A&MMS	Aquisitions and Materials Management Service	January 11, 2005
A&PC	Ambulatory and Primary Care	December 14, 2016
A/D	alcohol and drug	June 16, 2015
A/E	Architect/Engineer	November 22, 2005
A/H	Auditory Hallucinations	October 31, 2007
A/O	Administrative Offices	February 04, 2010
A/OPC	Agency/Organization Program Coordinator	May 02, 2007
A/R	Accounts Receivable	November 22, 2005
AA	Attorney-Adviser	July 13, 2004
AA	Authorized Absence	Added prior to March 2003

AAA	Authentication, Authorization & Access	July 13, 2004
AAA	Area Agencies on Aging	Added prior to March 2003
AAA	Abdominal Aortic Aneurysm	June 09, 2010
AAALAC	American Association for Accreditation of Laboratory Animal Care	March 18, 2009
AAAPS	Automatic Appraiser Assignment Processing Center	April 03, 2014
AABB	American Association of Blood Banks	November 22, 2005
AAC	Austin Automation Center (3/08 See AITC)	March 13, 2008
AACS	Automated Allocation & Control System	Added prior to March 2003
AADF	Activation Advance Development Fund	November 22, 2005
AAFES	Army and Air Force Exchange Service	December 15, 2016
AAFP	American Academy of Family Physicians	May 09, 2007
AAGP	American Association of Geriatric Psychiatry	March 17, 2009
AAH	Academy on Architecture for Health	November 22, 2005
AAH	Account Activity History	December 15, 2016
AAHRPP	Association for the Accreditation of Human Research Protection Programs	March 18, 2009
AAIP	Authorization and Authentication Infrastructure Program	September 24, 2004
AAMC	Association of American Medical Colleges	Added prior to March 2003
AAMI	Association for the Advancement of Medical Instrumentation	November 29, 2012
AAMS	Automated Acquisition Management System	February 18, 2010
AAR	After Action Report	November 05, 2008
AARP	Association for the Advancement of Retired Persons	February 18, 2010
AASLD	American Academy for the Study of Liver Disease	October 20, 2006
AB	antibiotic	October 10, 2006
ABC	Activity Based Costing	November 22, 2005
ABD OR ABD	Abdomen	August 04, 2014
ABEND	Abnormal End	February 18, 2010
ABG	Arterial Blood Gas	November 29, 2012
ABI	Analytics and Business Intelligence	April 09, 2014
ABO	Absent Bed Occupant	November 29, 2012
ABOI	Administrative Board of Investigation (ABOI)	April 30, 2014
ABR	Annual Benefits Report	April 23, 2014
ABX	Antibiotics	April 17, 2014
ABX OR ABX	Antibiotics	August 04, 2014
AC	Actual Cost	July 13, 2004
AC	Ambulatory Care	Added prior to March 2003
AC	Associate Chief of Staff	November 22, 2005
AC	Acceleration Clause	November 22, 2005
AC	anticubital	June 16, 2015
ACA	Advanced Clinic Access	April 27, 2004
ACA	Affordable Care Act	March 21, 2014

ACAP	Access and Clinic Administration Program	April 03, 2015
ACBE	Air Contrast Barium Enema	June 08, 2012
ACC	Ambulatory Care Center	December 08, 2011
ACC	Accounting Classification Code	November 22, 2005
ACCME	Accreditation Council for Continuing Medical Education	July 10, 2007
ACD	Automated Call Distributor	November 22, 2005
ACDF	Anterior Cervical Discectomy & Fusion	April 21, 2016
ACE	Acceptable Clinical Evidence	April 03, 2015
ACE	Accountable Customer Experience	February 06, 2015
ACEC	American Consulting Engineers Council	November 22, 2005
ACEP	American College of Emergency Physicians	Added prior to March 2003
ACES	Access Certificates for Electronic Services	Added prior to March 2003
ACES	Attendance and Cost Estimation System	May 07, 2014
ACG	Ambulatory Care Group	Added prior to March 2003
ACGME	Accreditation Council for Graduate Medical Education	Added prior to March 2003
ACH	Automated Clearing House	November 22, 2005
ACHE	American College of Health Executives	Added prior to March 2003
ACHP	Advisory Council on Historic Preservation	November 22, 2005
ACHS	before meals and at bedtime	October 29, 2015
ACI	American Concrete Institute	November 22, 2005
ACI	Accelerating Care Initiative	September 23, 2014
ACI	Accelerated Care Initiative	September 23, 2014
ACIO	Associate Chief Information Officer	July 13, 2004
ACL	Access Control List	March 23, 2007
ACL	Audit Command Language	December 15, 2016
ACLS	Advanced Cardiac Life Support	October 01, 2003
ACM	Audit Compliance Module	April 10, 2014
ACMD	Assistant Chief Medical Director	Added prior to March 2003
ACMIS	Acquisition Career Management Information System	February 18, 2010
ACNS	Associate Chief Nursing Service	July 12, 2006
ACO	Administrative Contracting Officer	November 22, 2005
ACOA	Adult Children of Alcoholics	November 22, 2005
ACOE	Accreditation Council on Optometric Education	November 22, 2005
ACOM	Associate Chief of Medicine	May 07, 2014
ACOS	Associate Chief of Staff	Added prior to March 2003
ACOS	American College of Surgeons	Added prior to March 2003
ACOS/E	Associate Chief of Staff for Education	Added prior to March 2003
ACOS/EC	Associate Chief of Staff for Extended Care	Added prior to March 2003
ACOVE	Assessing Care Of Vulnerable Elders	December 13, 2006
ACP	American College of Physicians	May 09, 2007

ACPE	American Council for Pharmaceutical Education	July 10, 2007
ACR	American College of Radiology	August 10, 2010
ACRB	Architectural Change and Review Board	November 22, 2005
ACRE	Artifact Central Repository	October 04, 2010
ACRP	Ambulatory Care Reporting Program	Added prior to March 2003
ACRS	Accelerated Cost Recovery System	November 22, 2005
ACS	Acute Coronary Syndrome	February 22, 2005
ACS	Access Services	December 15, 2016
ACT	Acceptance and Commitment Therapy	April 23, 2014
ACWP	Actual Cost for Work Performed	July 22, 2003
AD	Assistant Director	July 13, 2004
AD	Active Directory	June 08, 2005
AD	Advanced Directive	February 18, 2010
ADA	Antideficiency Act	September 20, 2010
ADA	Associate Deputy Administrator	Added prior to March 2003
ADA	American Diabetes Association	May 19, 2015
ADAAA	Americans with Disabilities Act Amendment Act	March 02, 2009
ADAAG	Americans with Disabilities Act Accessibility Guidelines	November 22, 2005
ADAD	After Date of Award Document	May 10, 2010
ADAPT	Ambulatory Detoxification and Preparation for Treatment	April 23, 2014
ADAS	Associate Deputy Assistant Secretary	Added prior to March 2003
ADC	Average Days to Complete	April 23, 2014
ADC	Average Daily Census	November 22, 2005
ADC	Active Dual Consumer	December 15, 2003
ADC	Alzheimer's Disease Center	March 17, 2009
ADC	Application Development Competency	February 06, 2015
ADCC	Alzheimer's Disease Core Center	November 22, 2005
ADCIO	Assistant Deputy Chief Information Officer	February 01, 2010
ADCMD	Associate Deputy Chief Medical Director	Added prior to March 2003
ADDM	Atrium Discovery & Dependency Mapping	March 23, 2015
ADDP	Assistant Director Development Program	December 10, 2014
ADE	Adverse Drug Event	November 09, 2004
ADERS	Adverse Drug Event Reporting System	December 18, 2007
ADFS	Active Directory Federated Services	April 06, 2006
ADHC	Adult Day Health Care	November 22, 2005
ADHF	Acute decompensated heart failure	October 22, 2015
ADI	Awaiting Development initiation	October 22, 2015
ADL	Automated Decision Letter	June 16, 2015
ADL	Activities of Daily Living	March 17, 2009
ADM	Acquisition Decision Memorandum	May 01, 2014
ADP	Automatic Data Processing	Added prior to March 2003

ADP	Average Days Pending	June 16, 2015
ADPAC	Automated Data Processing Application Coordinator	Added prior to March 2003
ADPSO	Automated Data Processing Security Officer	Added prior to March 2003
ADR	Average Daily Rate	November 22, 2005
ADR	Administrative Data Repository	June 08, 2005
ADR	Adverse Drug Event	November 09, 2004
ADR	Adverse Drug Reaction	July 13, 2004
ADR	Additional Development Review	October 12, 2010
ADR	Alternative Dispute Resolution	February 13, 2006
ADRADA	Alzheimer's Disease and Related Disorders Association	Added prior to March 2003
ADS	Average Daily Salary	November 22, 2005
ADSM	Active Duty Service Member	June 21, 2010
ADT	Automated Data Transfer	July 13, 2004
ADT	Admission/Discharge/Transfer	Added prior to March 2003
ADT/R	Admissions, Discharge, Transfer/Registration	Added prior to March 2003
ADT/R	Admission	March 24, 2011
ADUSH	VHA Assistant Deputy Under Secretary for Health (ADUSH)	March 26, 2009
AE	Application Entity	April 23, 2014
AECGIS	Automated Electrocardiographic Interpretive Systems	Added prior to March 2003
AECO	A/E Change Order	November 22, 2005
AED	Automated External Defibrillator	November 29, 2012
AED	Anti-Epileptic Drug	December 15, 2016
AEIC	Advanced Earned Income Credit	July 06, 2010
AEM	Area Emergency Manager	May 13, 2003
AEMAS	Affirmative Employment Monitoring and Analysis System	November 22, 2005
AEMS/MERS	Automated Engineering Management System/Medical Equipment Reporting	Added prior to March 2003
AEPS	Affiliated Education Programs Service	Added prior to March 2003
AERB	Architecture Engineering Review Board	June 11, 2014
AES	Advanced Encryption Standard	June 21, 2010
AES	Aeromedical Evacuation Squadron	May 26, 2011
AES	All Employee Survey	February 25, 2008
AES	American Epilepsy Society	December 15, 2016
AEU	Affected End User	June 25, 2014
AEW	Audit Error Worksheet	June 22, 2015
AF/SC	Air Force Surgeon General	November 22, 2005
AF/SG	Air Force Surgeon General	May 26, 2011
AFB	Allocated Functional Baseline	July 13, 2004
AFC	Austin Finance Center	November 22, 2005
AFCEA	Armed Forces Communications and Electronics Association	Added prior to March 2003

AFEB	Armed Forces Epidemiological Board	Added prior to March 2003
AFGE	American Federation of Government Employees	Added prior to March 2003
AFGE-NVAC	American Federation of Government Employees-National Veterans Affairs Council	October 01, 2008
AFHCAN	Alaska Federal Health Care Access Network	Added prior to March 2003
AFHCP	Alaska Federal Healthcare Partnership	Added prior to March 2003
AFHRA	Air Force Historical Research Agency	December 15, 2016
AFIB	Atrial Fibrillation	August 14, 2014
AFIB OR A FIB	Atrial Fibrillation	August 14, 2014
AFIP	Armed Forces Institute of Pathology	Added prior to March 2003
AFMA	Automated Fabrication of Mobility Acts	November 22, 2005
AFNOC	Air Force Network Operation Center	Added prior to March 2003
AFO	Ankle-Foot Orthosis	Added prior to March 2003
AFPS	Automated Folder Processing System	July 13, 2004
AFRRI	Armed Forces Radiobiology Research Institute	Added prior to March 2003
AFSN	Air Force Systems Network	Added prior to March 2003
AFVSS	afebrile, vital signs stable	May 01, 2014
AGC	Associated General Contractors of America	November 22, 2005
AGE	ACUTE GASTROENTERITIS	April 01, 2014
AGI	Adjusted Gross Income	November 22, 2005
AGO	Agent Orange	November 22, 2005
AGS	Adjacent Gravesite Set-Aside	July 13, 2004
AH/VH	Auditory Hallucinations/Visual Hallucinations	June 01, 2010
AHA	American Hospital Association	Added prior to March 2003
AHCPR	Agency for Health Care Policy & Research (see AHRQ)	Added prior to March 2003
AHE	Associated Health Education	November 22, 2005
AHERA	Asbestos Hazard Emergency Response Act	July 05, 2011
AHHA	American Holistic Health Association	August 14, 2008
AHIC	American Health Information Community (Now NeHC)	February 03, 2009
AHIMA	American Health Information Management Association	Added prior to March 2003
AHIP	America's Health Insurance Plans	May 27, 2016
AHIS	Automated Hospital Information System	May 19, 2015
AHJ	Authority Having Jurisdiction	November 22, 2005
AHLTA	Armed Forces Health Longitudinal Technology Application (DoD)	March 21, 2014
AHPA	American Health Planning Association	Added prior to March 2003
AHRQ	Agency for Healthcare Research and Quality (formerly AHCPR)	Added prior to March 2003
AHSE	American Society for Health Care Engineering	Added prior to March 2003
AHTLA	AHLTA - Armed Forces Health Longitudinal Technology	April 23, 2014
AI	Artificial Intelligence	July 13, 2004
AIA	American Institute of Architects	November 22, 2005
AIB	Administrative Investigation Board	May 07, 2014

AIBS	American Institute for Biological Sciences	November 22, 2005
AIC	Ambulatory Infusion Center	October 03, 2011
AIC	Architecture and Infrastructure Committee	October 04, 2010
AIC	Automated Information Center	Added prior to March 2003
AICC	Aviation Industry Computer-Based Training Committee	October 11, 2011
AICD	Automated Implantable Cardiovascular Defibrillator	November 22, 2005
AICPA	American Institute of Certified Public Accountants	April 17, 2014
AICS	Automated Information Collection Systems	Added prior to March 2003
AICUZ	Airport Clear Zones and Accident Potential Zones	November 22, 2005
AID	Applied Informatics Deployment	July 18, 2014
AIDE	Agile Integrated Development Environment	June 14, 2011
AIDS	Acquired Immune Deficiency Syndrome	Added prior to March 2003
AIFPS	Automated Insurance Folder Processing System	July 13, 2004
AIM	Applied Informatics Management	April 23, 2014
AIS	Automated Information System	Added prior to March 2003
AITBMR	Annual Information Technology Budget and Management Report	August 04, 2014
AITC	Austin Information Technology Center	March 13, 2008
AJCC	American Joint Commission on Cancer	Added prior to March 2003
AJN	American Journal of Nursing	November 22, 2005
AKA	Also Known As	May 12, 2010
AKA	above the knee amputation	October 25, 2011
AKC	Artificial Kidney Center	May 01, 2014
AKI	Acute Kidney Injury	October 27, 2009
AL	Annual Leave	November 17, 2008
AL	Assisted Living	March 17, 2009
AL	American Legion	Added prior to March 2003
ALA	American Legion Auxiliary	October 20, 2011
ALAC	Administrative and Loan Accounting	October 04, 2010
ALARA	As Low As Reasonably Achievable	April 25, 2011
ALB	Account Level Budgeter	April 23, 2014
ALBCC	Account Level Budget Cost Center	July 06, 2009
ALC	Agency Location Code	November 22, 2005
ALCON	All Concerned	March 23, 2015
ALF	assisted living facility	December 14, 2016
ALJ	Administrative Law Judge	November 22, 2005
ALOC	altered level of consciousness	September 23, 2014
ALOS	Average Length of Stay	October 18, 2005
ALS	Amyotrophic Lateral Sclerosis	November 08, 2010
ALTA	American Land Title Transfer	November 22, 2005
AMA	Against Medical Advice	January 25, 2008

AMA	American Medical Association	Added prior to March 2003
AMA CPT	American Medical Association Current Procedural Terminology	May 07, 2014
AMAS	Automated Monument Application System	March 15, 2010
AMAS	Automated Management Application System	Added prior to March 2003
AMB	Ambulance	August 14, 2014
AMB SURG	Ambulatory Surgery	April 10, 2014
AMC	appeals management center	April 23, 2014
AMEDD	Army Medical Department	August 17, 2005
AMI	Acute Myocardial Infarction	April 16, 2003
AMIA	American Medical Informatics Association	Added prior to March 2003
AMIE	Automated Medical Information Exchange	Added prior to March 2003
AMIS	Automated Management Information System	Added prior to March 2003
AMMS	Aquisition and Material Management Services	April 18, 2014
AMO	Account Management Office	December 15, 2016
AMOD	Admitting Officer of the Day	October 31, 2007
AMR	Automated Maintenance Reporting	July 28, 2003
AMS	Accu-Med Services	July 28, 2003
AMS	Automated Methadone System	July 15, 2004
AMS	Asset Management Service	Added prior to March 2003
AMS	altered mental status	September 23, 2014
AMSA	Advanced Medical Support Assistant	October 22, 2015
AMSUS	Association of Military Surgeons of the United States	Added prior to March 2003
AMT	amount	December 15, 2016
AMVAD	Automated Masterfile of VA Directives	November 22, 2005
AMVETS	American Veterans of World War II, Korea and Vietnam	Added prior to March 2003
ANA	American Nurses Association	November 22, 2005
ANACE	American Nursing Association Code of Ethics	April 11, 2007
ANCC	American Nurses Credentialing Center	July 10, 2007
ANG	Air National Guard	April 21, 2011
ANOVA	Analysis of Variance	November 22, 2005
ANR	Automated Notification Reporting (ANR)	April 17, 2014
ANR	Automated Notification Reporting	July 22, 2003
ANSI	American National Standards Institute	Added prior to March 2003
ANT	Another Neat Tool	January 25, 2006
AO	Authorizing Official	January 15, 2009
AO	Administrative Officer	July 20, 2010
AO	Agent Orange	Added prior to March 2003
AOA	Analysis of Alternatives	July 15, 2004
AOA	American Osteopathic Association	November 22, 2005
AOC	alteration of consciousness	April 23, 2014
AOCC	Annual Oversight Compliance Certificate	April 17, 2014

AOD	Administrative Officer of the Day	Added prior to March 2003
AOD	Administrator On Duty	May 07, 2014
AODL	Accounting of Disclosure Log	September 04, 2015
AONE	American Organization of Nurse Executives	May 03, 2011
AOPO	Agent Orange Projects Office	Added prior to March 2003
AOR	Agent Orange Registry	Added prior to March 2003
AOR	Area Of Responsibility	December 13, 2006
AOTA	American Occupational Therapy Association	Added prior to March 2003
AOU	Area of Use	October 31, 2007
AOWG	Agent Orange Working Group (White House)	Added prior to March 2003
AP	Ankle Pumps	September 23, 2008
AP	Apical Pulse	July 30, 2015
APA	American Psychological Association	March 17, 2009
APEC	Asian Pacific Economic Cooperative	Added prior to March 2003
APEO	Associate Deputy Program Executive Officer	January 09, 2006
APF	Advance Planning Fund	November 22, 2005
APG	Agency Priority Goal	April 30, 2014
API	Application Program Interface	Added prior to March 2003
API	Application Programming Interface	March 12, 2009
APM	Application Performance Management	December 15, 2016
APN	Advance Practice Nurse	June 08, 2010
APO	Area Processing Office	November 22, 2005
APO	Army Post Office	September 04, 2015
APOC	Administrative Point of Contact	June 27, 2011
APP	Alternating Pressure Pad	February 02, 2011
APP	Application Portability Profile	July 15, 2004
APP	Advanced Practice Professional	December 15, 2016
APPS	Advanced Practice ProfessionalS	April 21, 2016
APPT.	appointment	October 21, 2014
APRD	Accounting Policy & Reporting Division	August 03, 2011
APTA	American Physical Therapy Association	Added prior to March 2003
APW	Architecture Planning Workgroup	Added prior to March 2003
AQRS	Authorization Quality Review Specialist	December 14, 2016
AR	Accounts Receivable	Added prior to March 2003
AR	Architecture Requirements	July 15, 2004
AR/WS	Automatic Replenishment/Ward Stock	October 31, 2007
ARA	Automated Risk Assessment	Added prior to March 2003
ARAMIS	American Rheumatology Associates Medical Information System	Added prior to March 2003
ARB	Architecture Review Board	February 25, 2008
ARB	Accident Review Board	June 23, 2008

ARC	American Red Cross	June 06, 2006
ARC	Adult Rehabilitation Center	October 30, 2014
ARC	Amputation Rehabilitation Coordinator	September 23, 2011
ARC	Allocation Resource Center	Added prior to March 2003
ARCA	Aggregated Root Cause Analysis	October 20, 2011
ARCH	Access Received Closer to Home	April 30, 2014
ARF	Acute Renal Failure	February 06, 2015
ARF	Animal Research Facilities	Added prior to March 2003
ARG	Application Requirements Group	Added prior to March 2003
ARIWG	Architecture Requirements and Investment Working Group	December 10, 2014
ARK	Anesthesia Record Keeper	October 15, 2009
ARM	Automated Reference Manual	July 15, 2004
ARM	Adjustable Rate Mortgage Loan	November 22, 2005
ARMA	Association of Records Managers and Administrators	July 20, 2009
ARNG	ARMY NATIONAL GUARD	April 21, 2011
ARNG	ARMY NATIONAL GUARD	April 21, 2011
ARNP	Advanced Registered Nurse Practitioner	May 13, 2003
ARO	After Receipt of Order	May 12, 2010
ARO	After Receipt of Order	May 10, 2010
ARPA	Automated Request for Personnel Action	November 22, 2011
ARRA	American Recovery and Reinvestment Act	June 21, 2010
ARRT	American Registry of Radiologic Technologists	February 18, 2010
ARS	Automated Response System	Added prior to March 2003
ART	Adverse Reaction Tracking	Added prior to March 2003
ARTS	Adverse Reaction Tracking System	June 29, 2005
ARU	Alcohol Rehabilitation Unit	May 24, 2004
AS	Application Server	February 10, 2004
AS I&T	Assistant Secretary for Information & Technology	May 07, 2014
AS/IT	Assistant Secretary for Office of Information and Technology	June 11, 2014
ASA	Aspirin	Added prior to March 2003
ASA	Acetyl Salicylic Acid	July 20, 2010
ASAF	Automated System Access Forms	October 23, 2014
ASAM	American Society of Addiction Medicine	August 09, 2007
ASB	Ambulatory Surgery Basic	April 10, 2014
ASC	Additional Service Code	October 11, 2011
ASC X12	Accredited Standards Committee X12	July 15, 2004
ASCD	Automated Service Connection Designation	May 30, 2007
ASCII	American Standard Code for Information Interchange	July 15, 2004
ASCIP	Academy of Spinal Cord Injury Professionals	April 04, 2011
AsCMD	Associate Chief Medical Director	Added prior to March 2003
ASCP	American Society for Clinical Pathology	March 16, 2009

ASCVD	atherosclerotic cardiovascular disease	August 14, 2014
ASD	Architecture, Strategy and Design	October 04, 2010
ASD/HA	Assistant Secretary of Defense for Health Affairs	May 07, 2014
ASDP	American Society of Dermatopathology	April 30, 2014
ASE	Application Security Engine	July 15, 2004
AS-F	Acquisition Service - Frederick	April 15, 2014
ASHRM	American Society for Healthcare Risk Management	November 29, 2012
ASIA	American Spinal Injury Association	April 04, 2011
ASIH	Absent Sick In Hospital	Added prior to March 2003
ASIM	Automated Security Incident Measurement	Added prior to March 2003
ASIS	Application Structure and Integration Support	July 15, 2004
ASISTS	Automated Safety Incident Surveillance and Tracking System	Added prior to March 2003
ASLM	Application Service Line Manager	February 04, 2010
ASN.1	Abstract Syntax Notation One	July 27, 2009
ASOC	Amputee System of Care	February 18, 2010
ASP	Accrued Services Payable	March 31, 2010
ASP	Application Service Provider	July 15, 2004
ASP	Active Server Pages	Added prior to March 2003
ASP	Antimicrobial Stewardship Program	April 23, 2014
ASPEN	Automated Standardized Performance Elements Nationwide	April 23, 2014
ASPEN	Advanced Sites, Planning and Engineering Network	July 27, 2009
ASPEN	Automated Standardized Performance Elements Nationwide	April 30, 2014
ASPEN	Access Standardized Performance Elements Nationwide	April 30, 2014
ASSESS	Application Self-Scoring Evaluation Support System	Added prior to March 2003
ASSIST	Automated Safety Incident Surveillance System	November 24, 2010
ASTM	American Society for Testing and Materials	Added prior to March 2003
ASU	Authorization Subscription Utility	Added prior to March 2003
ASVAB	Armed Service Vocational Aptitude Battery	April 10, 2014
ASW	Architect Solution Worksheet	December 19, 2013
AT	Assistive Technology	September 23, 2014
AT	Addiction Therapist	October 25, 2006
ATA	Advanced Technology Attachment	February 02, 2006
ATC	Attempt To Contact	April 16, 2008
ATC	Attempted to Contact	November 30, 2009
ATIC	Advanced Technology Integration Center	Added prior to March 2003
ATM	Asynchronous Transfer Mode	Added prior to March 2003
ATO	Authority To Operate	July 29, 2004
ATOC	Authority To Operate with Conditions	October 29, 2015
ATOMS	Acquisition Task Order Management System	April 10, 2014
ATP	Acquisition Training Program	July 15, 2004

ATRA	American Therapeutic Recreation Association	May 28, 2009
ATS	Artificial Tears	October 28, 2011
ATS	Addiction Treatment Services	October 29, 2015
ATSD	Authority To Transmit Sensitive Data	September 08, 2011
AV	Architecture View	April 23, 2014
AV	Atrioventricular	August 04, 2014
AVA	Anthrax Vaccine Absorbed	April 11, 2007
AVANTI	Alpha VistA NT Implementation	February 01, 2005
AVH	Audio Visual Hallucinations	June 14, 2011
AVHE	?	January 21, 2016
AVHE	Application Virtualization and Hosting Environment	December 15, 2016
AVIVA	A Virtual Installation of VistA Architecture	April 08, 2010
AVO	Appraised Value Offer	December 14, 2016
AWE	Annual Workplace Evaluation	March 08, 2011
AWIV	Advanced Web Image Viewer	October 21, 2009
AWOL	Absent Without Leave	Added prior to March 2003
AWS	Alternate Work Schedule	November 22, 2005
AX	assessment	December 14, 2016
B		top
B	Bilateral or Both	August 14, 2014
B&D	Birch and Davis Associates, Inc.	Added prior to March 2003
B&P	Bid and Proposal	May 12, 2010
B/A	Basic Agreement	May 12, 2010
B/A	Basic Agreement	May 12, 2010
B/L	Bilateral	May 01, 2014
B/L	Bilateral	May 07, 2014
B/S	Benefits/Services	Added prior to March 2003
BA	Business Architecture	April 15, 2010
BAA	Business Associate Agreement(s)	April 27, 2004
BABOK	Business Analysis Body of Knowledge	May 07, 2014
BAC	Budget At Completion	July 22, 2003
BAFO	Best of Final Order	May 12, 2010
BAFO	Best of Final Order	May 12, 2010
BAH	Basic Allowance for Housing	December 01, 2010
BAH	Booz-Allen & Hamilton	Added prior to March 2003
BAS	Benefits Assistance Service	February 14, 2012
BBB	Bundle Branch Block	August 14, 2014
BBM	Blood Bank Modernization	Added prior to March 2003
BBS	Bulletin Board System	Added prior to March 2003
BC	blood culture	June 16, 2015

BC	Business Continuity	January 21, 2016
BCA	Business Continuity Plan	July 15, 2004
BCA	Board of Contract Appeals	May 12, 2010
BCAG	Business Community Advisory Group	April 11, 2007
BCAG	Business Community Advisory Group	February 06, 2015
BCBS	Blue Cross Blue Shield	April 15, 2010
BCE	Bar Code Expansion	March 08, 2006
BCE-PPI	Bar Code Enhancement - Positive Patient Identification	October 12, 2010
BCL	bar code letter	December 15, 2016
BCMA	Bar Code Medication Administration	Added prior to March 2003
BCMB	Business Capability Management Board	June 16, 2015
BCP	Business Continuity Planning	June 22, 2016
BCR	Baseline Change Request	April 11, 2007
BCRO	Bar Code Resource Office	August 06, 2007
BCS	Business Case Study	July 28, 2004
BCVA	Best Corrected Visual Acuity	December 15, 2016
BCWP	Budgeted Cost for Work Performed	July 22, 2003
BCWS	Budgeted Cost for Work Scheduled	July 22, 2003
BDC	Boston Development Center	Added prior to March 2003
BDC	Benefits Delivery Center	Added prior to March 2003
BDD	Benefits Delivery at Discharge	November 09, 2004
BDI	Biological Defense Initiative	Added prior to March 2003
BDL	Borderline	December 15, 2016
BDN	Benefits delivery network	April 17, 2015
BDN	Benefits Delivery Network	Added prior to March 2003
BDOC	Bed Days of Care	Added prior to March 2003
BEC	Benefits Executive Council	Added prior to March 2003
BEDB	Basic Employee Death Benefit	May 11, 2011
BESS	Biomedical Engineering Support Specialist	August 08, 2011
BEST	Business Enterprise Solutions and Technologies	Added prior to March 2003
BFA	Battlefield Acupuncture	April 21, 2016
BFEOB	Budget Formulation and Execution Line of Business	December 14, 2016
BFF	Business Function Framework	May 07, 2014
BFFS	Beneficiary Fiduciary Field System	April 17, 2015
BG	blood glucose	May 19, 2015
BGM	Blood Glucose Monitor	April 01, 2008
BH	Behavioral Health	November 08, 2010
BHAP	Behavior Health Autopsy Program	January 21, 2016
BHCG	Blood pregnancy test	August 14, 2014
BHIE	Bidirectional Health Information Exchange (Formerly DSI)	December 04, 2007
BHIP	Behavioral Health Interdisciplinary Program	April 23, 2014

BI	Background Investigation	April 28, 2010
BIA	Business Impact Analysis	February 14, 2012
BIBA	Brought in by ambulance, denotes how pt arrived to ER	July 25, 2014
BIBA	brought in by ambulance	July 25, 2014
BICP	BIRLS ICP Update	April 17, 2014
BID	twice daily	August 14, 2014
BIM	Business Implementation Manager	February 06, 2015
BIN	Banking Identification Number	August 11, 2006
BINQ	BIRLS Inquiry	April 17, 2014
BIPAP	Bilevel positive airway pressure	August 04, 2014
BIRLS	Beneficiary Identification and Records Locator System	March 15, 2010
BISL	Business Intelligence Service Line	June 11, 2014
BJP	Business Justification Package	May 07, 2014
BJA	Below Knee Amputation	March 13, 2006
BLOB	Binary Large Object	February 07, 2005
BLS	Basic Life Support	March 21, 2014
BLUF	Bottom Line Up Front	June 06, 2014
BM	Boewl movement	August 14, 2014
BME	Biomedical Engineering	February 24, 2004
BMI	Body Mass Index	Added prior to March 2003
BMP	Basic Metabolic Panel	July 20, 2009
BMS	Bed Management System	August 10, 2010
BMS	Bed Management Solution	July 30, 2015
BMT	Bone Marrow Transplantation	Added prior to March 2003
BMW	Bedside Mobile Workstation	December 08, 2011
BNI	Business Needs and Investment	April 16, 2008
BNIB	Business Needs and Investment Board	October 14, 2008
BNP	B-type Natriuretic Peptide	August 04, 2014
BNS	Business Needs Statement	May 07, 2014
BOA	Basic Ordering Agreement	May 10, 2010
BOC	Business Operations Committee	February 14, 2012
BOC	Budget Object Code	January 23, 2007
BOC	Buckey of Circuits	December 15, 2016
BOP	Budget Operating Plan	April 23, 2014
BOP	Bureau of Prisons	Added prior to March 2003
BOP	Budget Operating Plan	April 23, 2014
BOP	Budget Operating Plan	April 18, 2014
BOSS	Burial Operations Support System	Added prior to March 2003
BP	Blood Pressure	April 23, 2014
BPA	Blanket Purchase Agreement	Added prior to March 2003

BPC	Budget Policy Consultant	July 15, 2004
BPE	Business Partner Extranet	April 03, 2014
BPG	Business Partner Gateway	October 08, 2003
BPG	Business Process Group	May 07, 2014
BPH	Benign prostatic hyperplasia	June 08, 2012
BPIC	Business Performance Improvement Committee	April 02, 2007
BPMN	Business Process Model and Notation	May 07, 2014
BPMN	Business Process Model and Notation	April 23, 2014
BPR	Business Process Re-engineering	February 10, 2004
BPRA	Business Process Re-engineering and Analysis	May 07, 2014
BPRC	Budget Planning Review Council	Added prior to March 2003
BPSD	Benefits Product Support Division	October 23, 2014
BQ	Best Qualified	July 06, 2010
BR OR B/R	bathroom	August 14, 2014
BRBPR	BRIGHT RED BLOOD PER RECTUM	April 23, 2014
BRC	Blind Rehabilitation Centers	November 24, 2010
BRCD	Business Requirements Change Document	July 18, 2014
BRCD	BRCD	April 23, 2014
BRD	Business Requirements Document	August 17, 2011
BRD	Business Requirements Document	October 31, 2007
BRECC	Baltimore VA Rehabilitation and Extended Care Center (BRECC)	October 04, 2004
BREP	Business Requirements Engineering Process	October 16, 2006
BRH	Bureau of Radiological Health	Added prior to March 2003
BRIDG	Biomedical Research Integrated Domain Group	December 15, 2008
BRM	Business Relationship Meeting	May 12, 2010
BRM	Business Reference Model	July 15, 2004
BRMO	Business Relationship Management Office	April 15, 2014
BROS	Blind Rehabilitation Outpatient Specialists	August 12, 2009
BRP	Business Process Re-Engineering	July 29, 2004
BRS	Blind Rehabilitation Specialist	June 15, 2009
BRS	Breath Sounds	January 26, 2011
BRSV5	Blind Rehabilitation Service Version 5	April 09, 2014
BS	Business Sponsor	June 16, 2015
BSAD	Baseline System Architecture Document	October 18, 2005
BSC	Balanced Score Card	July 15, 2004
BSE	Broker Security Enhancement	September 23, 2014
BSN	Bachelor [or Baccalaureate] of Science in Nursing	July 28, 2010
BSOD	Blue Screen of Death	Added prior to March 2003
BTA	Business Transformation Agency	March 02, 2009
BTE	Behind the Ear	April 23, 2014
BTL	Bilateral Tubal Ligation	April 23, 2014

BTP	Beneficiary Travel Program	April 15, 2014
BTRF	Blood Transfusion Request Form	March 14, 2011
BTS	Business Transaction Service	April 23, 2014
BTT	Budget Tracking Tool	October 14, 2010
BUC	BUC	April 23, 2014
BUC	BUC	April 23, 2014
BUM	Bed Utilization Management	November 05, 2008
BUPD	BIRLS UPDATE	June 15, 2009
BURR	Building Utilization Review and Repurposing	June 27, 2011
BVA	Blinded Veterans of America	Added prior to March 2003
BVA	Board of Veterans' Appeals	Added prior to March 2003
BVAC	Behavioral VA Center	April 23, 2014
BVAMC	Boise VA Medical Center	December 03, 2014
BVAMC	Birmingham VA Medical Center	December 15, 2016
BVM	bag valve mask	August 04, 2014
BX	biopsy	October 21, 2014
C		top
C	C, a general-purpose programming language	Added prior to March 2003
C & P	Compensation and Pension Examinations	April 21, 2016
C&A	Certification and Authority	July 15, 2004
C&C	Confirmed and Continued	December 15, 2016
C&P	Compensation & Physical	Added prior to March 2003
C&P	Credentialing & Privileging	Added prior to March 2003
C&P	Compensation & Pension	Added prior to March 2003
C&S OR C/S	cultur and sensitivity	August 14, 2014
C&V	Construction & Valuation	October 04, 2010
C.O.D.	Contract on Delivery	May 12, 2010
C/O	complains of	December 15, 2016
C/O OR C/O	Complaint of	August 04, 2014
C/R	call reference	December 15, 2016
C32	Construct 32	June 21, 2010
C3PO	Chief, Policy, Planning and Performance Office	Added prior to March 2003
C4	Colorectal Cancer Care Continuum	June 12, 2007
CA	Certificate Authority	July 15, 2004
CA	Claims Assistant	December 15, 2016
CA&E	Corporate Analysis and Evaluation	April 17, 2014
CAAD	Central Acquisition Analysis Division	February 20, 2007
CAATS	Centralized Administrative Accounting Transaction System	February 23, 2011
CAB	Clinical Advisory Board	May 19, 2006
CAB	Combat Action Badge	December 14, 2016

CABG	Coronary Artery Bypass Graft	December 15, 2008
CABIG	Cancer Biomedical Informatics Grid	November 27, 2007
CAC	Common Access Card	June 27, 2011
CAC	Clinical Application Coordinator	July 15, 2004
CACP	Computer Application Change Plan	April 23, 2014
CACP	Computer Application CHange Plan	April 23, 2014
CACP	Computer Application Change Plan	April 03, 2014
CAD	Computer-Aided Design	July 15, 2004
CAD	Coronary artery disease	December 28, 2005
CADHC	Contract Adult Day Health Care	May 19, 2006
CADRE	COMPREHENSIVE ACCESS & DELIVERY RESEARCH & EVALUATION	April 30, 2014
CAF	Customer Acceptance Form	June 14, 2011
CAG	Citrix Access Gateway	July 27, 2011
CAG-20	Consensus Audit Guidelines - 20 Critical Security Controls for Effective Cyber Defense	April 03, 2015
CAH	Critical Access Hospital	February 07, 2011
CAI	Center for Acquisition Innovation	April 27, 2009
CAIP	Cross-Application Integration Protocol	July 15, 2004
CAIRO	Center for Applied Informatics Research and Operations	February 25, 2008
CALM	Centralized Accounting for Local Management	Added prior to March 2003
CAMPS	Capital Asset Management and Planning Service	January 11, 2010
CAMS	Capital Asset Management System	October 29, 2003
CANX	cancelled, cancel	February 06, 2015
CAO	Chief Administrative Officer	Added prior to March 2003
CAO	Competency Aligned Organization	May 09, 2006
CAO	Chief Acquistition Officer	May 12, 2010
CAO	Contract Administration Office	May 12, 2010
CAP	Capital Assessment Process	April 23, 2014
CAP	Corrective Action Plan	October 06, 2011
CAP	Combined Assessment Program	December 01, 2006
CAP	Capital Assessment Process	April 10, 2014
CAP	College of American Pathologists	Added prior to March 2003
CAPA	Corrective and Preventative Action	Added prior to March 2003
CAPE	Cost Assessment and Program Evaluation	May 07, 2014
CAPER	Compensation And Pension Evaluation Redesign	Added prior to March 2003
CAPOC	Computer Assisted Practice of Cariology (DoD)	Added prior to March 2003
CAPPS	Computer Assisted Payments Processing System	Added prior to March 2003
CAPPS	Capital Asset Policy, Planning, and Strategy Service	April 03, 2014
CAPRES	Capital Resource (Survey)	January 24, 2007
CAPRI	Compensation and Pension Record Interchange	April 15, 2010
CAPS	Computerized Accounts Payable System	July 15, 2004

CAPS	Capabilities Assessment Program Survey	November 05, 2008
CAR	Combat Action Ribbon	December 14, 2016
CAR	Collection, Analysis, and Reporting tool	December 14, 2016
CARA	Criticality Analysis and Risk Assessment	June 27, 2011
CARD	Cost Analysis Requirements Description	April 30, 2014
CARDS	Cardiology	August 14, 2014
CARE	Continuity Assessment Records and Evaluation	March 02, 2009
CARES	Capital Asset Realignment for Enhanced Services	Added prior to March 2003
CARF	Commission on Accreditation of Rehabilitation Facilities	Added prior to March 2003
CARF	Computer Access Request Form	May 09, 2011
CARG	Clinical Application Requirements Group	Added prior to March 2003
CAROLS	Centralized Accounts Receivable On-Line System	Added prior to March 2003
CART	Clinical Assessment Reporting and Tracking	October 01, 2014
CART	Cardiovascular Assessment Reporting and Tracking	July 06, 2009
CART-CL	Cardiovascular Assessment Reporting and Tracking - Catheterization Lab	July 06, 2009
CAS	Cost Accounting Standard	May 12, 2010
CASB	Cost Accounting Standards Board	May 12, 2010
CASE	Computer Assisted Software Engineering	July 15, 2004
CASES	Clarify, Assemble, Synthesize, Explain and Support	April 23, 2014
CASS	Computer Assisted System Staff	May 19, 2015
CAT	Computerized Aril Topography	Added prior to March 2003
CAT	Computerized Axial Tomography	Added prior to March 2003
CAT	Computer Audio Teleconferencing	Added prior to March 2003
CAT	Computer Access Training	May 07, 2014
CAT	Computer Access Training	May 07, 2014
CATH	Catheter, as in Urinary Catheter or Cardiac Catheterization	August 14, 2014
CATS	Compliance and Tracking System	April 23, 2014
CATS	Complaints Automated Tracking System	October 22, 2015
CAU	Clinical Access Unit	May 01, 2014
CAUTI	Catheter Acquired Urinary Tract Infection	March 28, 2011
CAVC	Court of Appeals for Veterans Claims	October 28, 2011
CAVHCS	Central Alabama Veterans Health Care System	December 15, 2016
CAVHS	Central Arkansas Veterans Healthcare System	May 20, 2010
CB	Care Bereavement	July 21, 2010
CBA	Cost Benefit Analysis	July 15, 2004
CBA	Clinical Business Area	Added prior to March 2003
CBA	Centrally Billied Account	December 12, 2014
CBC	Community Based Outpatient Clinic	July 21, 2004
CBC	Complete Blood Count	May 26, 2010
CBCMC	Clinical Bar Code Multidisciplinary Committee	August 17, 2009

CBD	Chief Benefits Director	Added prior to March 2003
CBHCO	Community-Based Health Care Organization	June 10, 2004
CBI	Compliance and Business Integrity	Added prior to March 2003
CBIR	Call Bell In Reach	March 23, 2015
CBO	Chief Business Office	November 15, 2010
CBO	Congressional Budget Office	Added prior to March 2003
CBOC	Community-Based Outpatient Clinic	November 29, 2012
CBOPC	Chief Business Office Purchased Care	April 23, 2014
CBRRP	Community Based Residential Recovery Program	January 03, 2007
CBSE	Component Based Software Engineering	July 15, 2004
CBT	Computer-Based Training	July 15, 2004
CBT	Cognitive Behavioral Therapy	September 23, 2008
CC	Celing Cost	May 12, 2010
CC	Configuration Control	July 15, 2004
CC	Complains of	August 04, 2014
CC	Chief Counsel	April 21, 2016
CC	Care Coordinator	January 21, 2016
CCA	Clinger-Cohen Act	Added prior to March 2003
CCA	Consolidated Contracting Activity	June 29, 2007
CCB	Change Control Board	Added prior to March 2003
CCC	Cost Containment Center	Added prior to March 2003
CCD	Centralized Contracting Division	July 15, 2004
CCD	Continuity of Care Document	December 14, 2005
CCDA	Consolidated Clinical Document Architecture	February 06, 2015
C-CDA	Consolidated Clinical Document Architecture	April 17, 2014
CCDOR	Center for Chronic Disease Outcomes Research	June 08, 2009
CCDSS	Clinical Care Delivery Support System	April 28, 2009
CCEP	Comprehensive Clinical Evaluation Program	July 10, 2007
CCHHIP	Care Coordination Home Health Infrastructure Project	July 17, 2003
CCHIT	Certification Commission for Health Information Technology	April 24, 2006
CCHT	Care Coordination Home Telehealth	October 10, 2006
CCIP	Coordinated Care Implementation Project	October 01, 2003
CCITT	Consultative Committee for International Telephone and Telegraphy	July 15, 2004
CCM	Coding Compliant Module	April 10, 2014
CCM	Certified Case Manager	March 05, 2009
CCMB	CLINICAL CARE MANAGEMENT BOARD	December 10, 2014
CCMD	Call Center MD/ Physicians	July 30, 2015
CCNE	Commission on Collegiate Nursing Education	April 11, 2007
CCO	Community Collaboration Office	Added prior to March 2003
CCO&TPS	Charge Card Oversight and Travel Policy Services	March 31, 2010

CCOD	Charge Card Operations Division	December 15, 2016
CCOW	Clinical Context Object Workgroup	Added prior to March 2003
CCPC	Consolidated Co-payment Processing Center	Added prior to March 2003
CCQAS	Centralized Credentials and Quality Assurance System	Added prior to March 2003
CCR	Central Contractor Register	February 18, 2010
CCR	Continuity of Care Record	December 14, 2005
CCR	Clinical Case Registry	December 14, 2005
CCRS	Code Change Requests	April 23, 2014
CCS	CHDR Common Service	October 22, 2003
CCS	Care Coordination Services	January 06, 2009
CCSP	Child Care Subsidy Program	December 21, 2011
CCT	Critical Care Transport	August 14, 2014
CCT	Community Care Team	December 15, 2016
CCU	Consolidated Classification Unit	December 12, 2014
CD	Catastrophic Disability	July 15, 2004
CD ROM	Compact Disk Read-Only Memory	Added prior to March 2003
CDA	Clinical Documentation Architecture	June 27, 2005
CDA	Contract Disputes Act	May 12, 2010
CDA	Certified Dental Assistant	June 10, 2008
CDASH	Clinical Data Acquisition Standards Harmonization	December 15, 2008
CDB	Cough, Deep Breath	May 20, 2010
CDC	Centers for Disease Control and Prevention	Added prior to March 2003
CDCI	Corporate Data Center COOP Initiative	Added prior to March 2003
CDCO	Corporate Data Center Operations (formerly CFDC)	March 13, 2008
CDD	Capabilities Development Document	May 07, 2014
CDDT	Capability Deep Dive Team	May 07, 2014
CDE	Clinical Data Enhancement	March 08, 2007
CDF	Corporate Data Franchise Center	February 25, 2008
CDF	Capability Development Framework	May 07, 2014
CDI	clean, dry and intact	December 15, 2004
CDI	Clostridium difficile infection	April 17, 2014
CDI	Clinical Documentation Improvement	April 10, 2014
CDI	Customer Data Integration	January 21, 2016
CDIS	Clinical Documentation Improvement Specialist	April 10, 2014
CDIS	Clinical Documenation Improvement Specialist	April 17, 2014
CDISC	Clinical Data Interchange Standards Consortium	February 25, 2008
CDM	Chronic Disease Management	April 25, 2011
CDM	canonical data model	April 18, 2014
CDM	Continuous Diagnostics and Monitoring	January 21, 2016
CDN	Content Distribution Network	February 10, 2004

CDP	Concurrent Disability Pay	April 17, 2014
CDQR	Clinical Data Quality Review	Added prior to March 2003
CDR	Clinical Data Repository	July 15, 2004
CDR	Cost Distribution Report	Added prior to March 2003
CDR	Commission on Dietetic Registration	July 10, 2007
CDR	Critical Design Review	August 10, 2010
CDS	Clinical Decision Support	May 07, 2014
CDS	Clinical Decision Support	April 10, 2014
CDS	Clinical Data Services	June 10, 2004
CDSS	Clinical Decision Support System	Added prior to March 2003
CDT	Current Dental Terminology	July 15, 2004
CDW	Corporate Data Warehouse	July 15, 2004
CE	Continuing Education	Added prior to March 2003
CEA	Chief Enterprise Architect	July 15, 2004
CEB	Clinical Executive Board	April 23, 2014
CEC	Clinical Ethics Consultation	April 23, 2014
CEC	Continuing Education Center	Added prior to March 2003
CEC	VA Commodities Enterprise Contract	April 21, 2016
CEC	Community Employment Coordinator	December 14, 2016
CEFU	Continuing Education Field Unit	March 27, 2006
CEHIST	Center for Evaluation of Healthcare Information Systems & Technology	Added prior to March 2003
CEIS	Corporate Executive Information System	Added prior to March 2003
CELO	Chief Education Liaison Officers	September 23, 2014
CEMP	Comprehensive Emergency Management Program	May 28, 2009
CEMP	Comprehensive Emergency Management Program	April 17, 2014
CEN	Committee European de Normalisation	July 15, 2004
CEO	Chief Executive Officer	Added prior to March 2003
CEOSH	Center for Engineering & Occupational Safety and Health	December 22, 2009
CERME	CareEnhance Review Manager Software	March 23, 2007
CERME	Care Enhanced Review Management Enterprise	April 30, 2014
CERS	Community Engagement and Reintegration Services	April 21, 2016
CERT	Computer Emergency Response Team	April 02, 2007
CESAMH	Center of Excellence for Stress and Mental Health	October 09, 2007
CESATE	Center of Excellence in Substance Abuse Treatment and Education	April 30, 2014
CEST	Claims Establishment	February 18, 2010
CFC	Court of Federal Claims	May 12, 2010
CFC	Combined Federal Campaign	January 11, 2005
CFD	Corporate Franchise Datacenter (3/08 see CDCO)	March 13, 2008
CFDA	Catalog of Federal Domestic Assistance	April 23, 2014
CFI	Claim for Increase	May 19, 2015

CFID	Change of Fiduciary	April 17, 2014
C-FILE	Claims File	October 22, 2015
CFIM	Customer Facing Incident Management Dashboard	December 14, 2016
CFM	Construction & Facilities Management	February 06, 2015
CFO	Chief Financial Officer	Added prior to March 2003
CFOC	Chief Financial Officers Council	May 12, 2010
CFP	Clinical Financial Planner	Added prior to March 2003
CFR	Code of Federal Regulations	Added prior to March 2003
CGA	contact guard assist	April 23, 2014
CGMP	Certified Government Meeting Professional	April 03, 2014
CHADS2	CHADS2 score	April 18, 2014
CHALENG	Community Homeless Assessment Local Education Networking Groups	August 07, 2008
CHAMPUS	Civilian Health & Medical Program of the Uniformed Services	Added prior to March 2003
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs	Added prior to March 2003
CHAP	chaplain	May 01, 2014
CHB	COMPLETE HEART BLOCK	October 29, 2015
CHCS	Composite Health Care System (DoD)	Added prior to March 2003
CHDR	Clinical/Health Data Repository	April 15, 2010
CHEC	Community Health Education Center	Added prior to March 2003
CHEP	Cooperative Health Manpower Education Programs	Added prior to March 2003
CHERP	Center for Health Research Equity and Promotion	July 28, 2008
CHF	Congestive Heart Failure	January 23, 2008
CHI	Consolidated Health Informatics	May 21, 2003
CHIM	Center for Healthcare Information Management	Added prior to March 2003
CHIME	College of Healthcare Information Management Executives	Added prior to March 2003
CHIN	Community Health Information Network	Added prior to March 2003
CHIO	Chief Health Informatics Office(r)	June 19, 2007
CHIP	Collaborative Health Information Partners	December 14, 2005
CHIP	Collaborative Health Information Partners	December 14, 2005
CHIPS	Consumer Health Information & Performance Set	Added prior to March 2003
CHIR	Consortium for Healthcare Informatics Research	March 15, 2010
CHIS	Center for Healthcare Information Security	Added prior to March 2003
CHISS	Common Health Information Security Service	Added prior to March 2003
CHO	carbohydrate	February 06, 2015
CHOMP	Community Hospital of Monterey Peninsula	October 14, 2008
CHPPM	U. S. Army Center for Health Promotion and Preventive Medicine	November 05, 2008
CHR	Consolidated Health Record	July 15, 2004
CHS	Columbus House Shelter	February 16, 2011
CHSS	Certified HIPAA Security Specialist Certification	December 04, 2008

CHUI	Character-based User Interface	December 11, 2007
CI	Contract Item/Control Item	May 12, 2010
CI	Configurable Item	May 07, 2014
CI	Commercial Integrator	Added prior to March 2003
CI/ST	Component integration/system test	April 17, 2015
CIC	Clean Intermittent Catheterization	June 16, 2015
CICA	Competition in Contracting Act	May 12, 2010
CICSP	Continuous Improvement In Cardiac Surgery Program	April 10, 2003
CID	Criminal Investigation Division	March 28, 2011
CID	Clinically Indicated Date	December 10, 2014
CIDC	Clinical Indicators Data Capture	August 29, 2005
CIDD	Common Intrusion Detection Director	Added prior to March 2003
CIDP	Chronic Inflammatory Demyelinating Polyneuropathy	April 21, 2016
CIF	Code In flight	October 30, 2014
CIIF	Common Information Interoperability Framework	May 03, 2011
CIIRP	Comprehensive Integrated Inpatient Rehabilitation Program	April 04, 2011
CIM	Corporate Information Model	July 15, 2004
CIO	Chief Information Officer	Added prior to March 2003
CIO NTEO	Chief Information Office National Training and Education Office	Added prior to March 2003
CIOFO	Chief Information Office Field Office	July 15, 2004
CIP	Capital Investment Proposal	Added prior to March 2003
CIP	Capital Investment Process	February 18, 2010
CIP	Critical Infrastructure Protection	December 14, 2016
CIPP/G	Certified Information Privacy Professional/Government	February 18, 2010
C-IPT	Capability Integrated Project Team	May 07, 2014
CIRC	Central Incident Response Capability	Added prior to March 2003
CIRD	Clinical Informatics and Requirements Division	April 23, 2014
CIRD	Clinical Informatics & Requirements Directorate	April 23, 2014
CIRN	Clinical Information Resources Network	Added prior to March 2003
CIRN-CR	CIRN-Clinical Respository	Added prior to March 2003
CIRT	Critical Incident Response Team	July 15, 2004
CIS	Clinical Information System	Added prior to March 2003
CIS/ARK	ICU Clinical Information System and Anesthesia Record Keeping System	April 30, 2014
CISS	Clinical Information Support System	February 25, 2008
CISS-OHRS	Clinical Information Support System - Occupational Health Record-keeping System	January 11, 2010
CISSP	Certified Information System Security Professional	May 22, 2003
CITE	Community Information Technology Engagement Program	June 11, 2014
CITI	CHAMPVA In-house Treatment Initiative	Added prior to March 2003
CITL	Center for Information Technology Leadership	October 16, 2006

CITN	Critical Incident Tracking Notification	April 17, 2015
CITPO	Clinical Information Technology Program Office	Added prior to March 2003
CIWA	Clinical Institute Withdrawal Assessment	June 14, 2011
CIWD	Condition Interfered With Duty	December 03, 2009
CKD	Chronic kidney disease	December 22, 2005
CLA	Customer License Agreement	Added prior to March 2003
CLABSI	Central Line-Associated Bloodstream Infection	April 25, 2011
CLASS	Community Living Assistance Services and Supports	July 06, 2010
CLC	Community Living Center	July 30, 2008
CLIA	Clinical Laboratory Improvement Amendment	Added prior to March 2003
CLIN	Contract Line Item Number	March 27, 2007
CLIO	Clinical Observations	October 15, 2009
CLO	Committee Liaison Office	March 08, 2010
CLO	Chief Logistics Officer	March 09, 2009
CLOB	Character Large Object	January 27, 2005
CLS	Clinical Lexicon Consortium	Added prior to March 2003
CM	Case Manager	June 11, 2014
CM	Configuration Management	July 15, 2004
CM	Change Management	July 15, 2004
CM	Contact Management	July 15, 2004
CM/SWS	Care Management and Social Work Services	July 30, 2015
CMAC	CHAMPUS Maximum Allowable Charges	Added prior to March 2003
CMC	Consolidated Medical Center	Added prior to March 2003
CMCHS	Civilian Military Contingency Hospital System	Added prior to March 2003
CMCOM	Configuration Management Process Committee	June 02, 2006
CMD	Chief Medical Director	Added prior to March 2003
CMDB	Configuration Management Database	May 01, 2014
CME	Continuing Medical Education	January 10, 2006
CMHC	Community Mental Health Center	February 07, 2011
CMi	Chronic Mental Illness	July 08, 2008
CMIO	Chief Medical Information Officer	May 07, 2014
CMIT	Current Medical Information and Terminology	Added prior to March 2003
CMM	Capability Maturity Model	July 15, 2004
CMMI	Capability Maturity Model Integration	March 27, 2007
CMO	Chief Medical Officer	July 06, 2009
CMOP	Consolidated Mail Outpatient Pharmacy	Added prior to March 2003
CMOR	CIRN Master of Record (replaced by PV)	October 02, 2007
CMP	Configuration Management Plan	July 15, 2004
CMP	Centralized Mail Portal	March 23, 2015
CMP (Labs)	Comprehensive Metabolic Panel	July 20, 2009
CMR	Consolidated Memorandum of Receipt	Added prior to March 2003

CMS	Centers for Medicare & Medicaid Services (previously HCFA)	Added prior to March 2003
CMS	Content Management Services	October 11, 2011
CMSTP	circulation motor sensation temperature pulse	April 23, 2014
CMT	Centralized Means Test	Added prior to March 2003
CMTRA	Care Management Tracking and Reporting Application	December 15, 2008
CNBD	COULD NOT BE DETERMINED	April 03, 2006
CNE	Certified Network Engineer	Added prior to March 2003
CNH	Community Nursing Home	August 11, 2006
CNH	Contract Nursing Homes	May 19, 2015
CNHC	Community Nursing Home Care	Added prior to March 2003
CNIO	Chief Nursing Informatics Office	July 18, 2014
CNO	Chief Network Officer	Added prior to March 2003
CNP	Controlled national policy	July 30, 2015
CNS	Central Nervous System	December 15, 2016
CNS	Clinical Nurse Specialist	April 04, 2011
CNSD	Clinical Nurse Staff Development	April 23, 2014
CO	Central Office	Added prior to March 2003
CO	Contracting Officer	April 23, 2014
CO	close observation	August 04, 2014
CO	Change Order	February 22, 2010
CO OR C.O.	Constant Observation (for pts with SI/HI concerns)	August 04, 2014
COAS	Clinical Observation Access Control	Added prior to March 2003
COB	Close of Business	April 09, 2009
COBOL	Common Business Oriented Language	April 17, 2015
COBRA	Consolidated Omnibus Budget Reconciliation Act	September 23, 2014
COBRA	Common Object Request Broker Architecture	July 15, 2004
COD	Character of Discharge	April 23, 2014
COE	Certificate of Eligibility	July 15, 2004
COE	Centers of Excellence	May 25, 2006
COFC	Court of Federal Claims	May 12, 2010
COG	Coninuity of Government	Added prior to March 2003
COG	Clinical Oversight Group	Added prior to March 2003
COHIC	National Center for Occupational Health and Infection Control	April 30, 2014
COHRS	Central Office Human Resources Service	March 31, 2009
COI	Conflict of Interest	May 12, 2010
COI	Communities of Interest	November 16, 2004
COIN	Center of Innovation	April 23, 2014
COLA	COST OF LIVING ADJUSTMENT	April 23, 2014
COLLAGE	Communities On-line Learning About Guidelines	January 23, 2007
COLMR	Center for Organization, Leadership, and Management Research	November 04, 2011

COLT	Clinical Online Training	October 16, 2008
Columbia HCA	Columbia Health Care Corporation	Added prior to March 2003
COM+	Component Object Model +	July 15, 2004
COMSEC	Computer Security	July 15, 2004
CONOPS	Concept of Operations	Added prior to March 2003
CONUS	Continental United States	November 05, 2008
COO	Chief Operations Officer	Added prior to March 2003
COOP	Continuity of Operations Plan	December 21, 2010
COOP	Continuity of Operations	April 17, 2014
COPD	Chronic Obstructive Pulmonary Disease	April 25, 2011
COPS	Community Outpatient Services	April 21, 2010
COR	Contracting Officer's Representative	May 12, 2010
COR	Copy of Record	Added prior to March 2003
CORBA	Common Object Request Broker Architecture	Added prior to March 2003
CORBA/OMA	Common Object Request Broker Architecture/Object Management Architectur	Added prior to March 2003
CORE	Clinical Observations Recording and Encoding	June 02, 2010
COREFLS	Core Financial and Logistics System	February 24, 2004
CORI	Clinical Outcomes Research Initiative (CORI)	January 11, 2010
CORK	Conference Oversight and Reporting Knowledgebase	April 21, 2016
COS	Chief of Staff	Added prior to March 2003
COSG	Collaborative Opportunities Steering Group	August 26, 2005
COSVA	Chief of Staff	January 29, 2009
COTR	Contracting Officer's Technical Representative	May 12, 2010
COTR	Contracting Officer's Technical Representative	Added prior to March 2003
COTS	Commercial-Off-The-Shelf (applications)	Added prior to March 2003
COVERS	Control of Veterans Records System	July 05, 2011
COW	Computer on Wheels	May 06, 2009
CP	Celing Price	May 12, 2010
CP	Chest pain	August 04, 2014
CP	Contingency Plan	July 15, 2004
CP	Counseling Psychologist	July 15, 2004
CP/SOB/N/V/D/F/C/HA	Chest pain/shortness of breath/nausea/vomiting/diarrhea/fever/chills/head ache	July 25, 2014
CP/SOB/N/V/D/F/C/HA	Chest pain/shortness of breath/nausea/vomiting/diarrhea/fever/chills/head ache	July 25, 2014
CPAC	Consolidated Patient Account Center	January 22, 2009
CPAP	Continuous Positive Airway Pressure	April 30, 2014
CPARS	Contractor Performance Assessment Reporting System	May 12, 2010
CPC	Comprehensive Primary Care	April 23, 2014
CPE	Clinical Pastoral Education	June 14, 2011
CPE	Continuing Professional Education	September 23, 2014

CPE	Claims Processing and Eligibility	September 23, 2014
CPE	Clinical Practice Environment	February 21, 2007
CPEP	Compensation and Pension Examination Project	Added prior to March 2003
CPFF	COST-PLUS-FIXED-FEE	September 04, 2015
CPG	Clinical Practice Guideline	April 10, 2014
CPGI	Clinical Practice Guidelines Index	February 20, 2007
CPGI	Clinical Practice Guidelines Index	March 14, 2011
CPI	Cost Performance Index	July 22, 2003
CPIC	Capital Planning and Investment Control	May 12, 2003
CPIF	COST PLUS INCENTIVE FEE	September 04, 2015
CPKM	Compensation Pension Knowledge Management	July 30, 2015
CPM	Continue Prescribed Medication(s)	December 14, 2016
CPM	Critical Path Method	Added prior to March 2003
CPM	Continuous Passive Motion	September 18, 2008
CPMB	Clinical Proponents' Management Board	May 27, 2016
CPMP	Contractor Program Management Plan	June 25, 2014
CPO	Certification Program Office	April 03, 2014
CPO	Chief of Purchasing Office	May 12, 2010
CPOE	Computerized Physician Order Entry	Added prior to March 2003
CPP	Consumer Preferences and Policy	June 14, 2011
CPR	Cardio-Pulmonary Resuscitation	July 14, 2003
CPR	Computer Patient Record	Added prior to March 2003
CPRI	Computer-Based Patient Record Institute	Added prior to March 2003
CPRI-HOST	Computer-based Patient Record Institute - Healthcare Open Systems and Trials	July 15, 2004
CPRR	Cost per [Patient] Reportable Result	April 01, 2014
CPRS	Computerized Patient Record System	Added prior to March 2003
CPRS-R	Computerized Patient Record System Reengineered	July 15, 2004
CPS	Certified Peer Specialist	April 23, 2014
CPS	Claims Processing Style	Added prior to March 2003
CPS	Claims Processing System	Added prior to March 2003
CPS	Core Products and Services	October 04, 2010
CPS	Contractor Performance System	February 18, 2010
CPS	Clinical Product Support	October 21, 2009
CPS	clinical pharmacy specialist	April 21, 2016
CPSC	Cardiac Pacemaker Surveillance Center	Added prior to March 2003
CPSR	Contractor Procurement System Review	May 12, 2010
CPT	Current Procedural Terminology	Added prior to March 2003
CPT	Cognitive Processing Therapy	September 04, 2015
CPTMS	Corporate Performance and Talent Management System	April 23, 2014

CPTMS	CSEMO Performance and Talent Management System	April 23, 2014
CPU	Central Processing Unit	Added prior to March 2003
CPWM	Compensation and Pension Worksheet Module	August 30, 2004
CQ	Clear Quest	June 02, 2006
CQI	Continuous Quality Improvement	July 15, 2004
CR	Clinical Reminders	April 17, 2014
CR	Change Request	March 27, 2007
CRADA	Collaborative Research and Development Agreements	Added prior to March 2003
CRADA	Cooperative Research and Development	April 27, 2004
CRADA	Cooperative Research and Development	April 27, 2004
CRADO	Chief Research and Development Officer	February 25, 2008
CRC	Community Residential Care Program	January 03, 2007
CRC	Certified Rehabilitation Counselor	April 07, 2011
CRC	Cyclic Redundancy Checks	July 15, 2004
CRDC	Capital Region Data Center	November 19, 2008
CRDP	Concurrent Retirement and Disability Payment	March 15, 2010
CREW Initiative	Civility, Respect and Engagement in the Workplace	September 13, 2005
CRISP	Computer Retrieval of Information on Scientific Projects	November 08, 2010
CRISP	Continuous Readiness in Information Security Program	June 04, 2012
CRM-UD	Customer Relationship Management - Unified Desktop	April 17, 2014
CRNA	Certified Registered Nurse Anesthetist	August 19, 2011
CRO	Chief Risk Officer	June 11, 2014
CRP	Capabilities Requirement Proposal	April 30, 2014
CRQS	Chief Residency in Quality and Patient Safety	April 23, 2014
CRRC	Community Resource and Referral Center	April 17, 2014
CRRC	Capital Region Readiness Center	March 24, 2011
CRRN	Certified Rehabilitation Registered Nurse	April 04, 2011
CRS	Converged Registries Solution	October 25, 2011
CRS	Care Record Summary	December 14, 2005
CRS	Chronic Rhinosinusitis	April 17, 2015
CRSC	Combat-Related Special Compensation	May 06, 2009
CRSP	Centralized Regional Scheduling Program	Added prior to March 2003
CRT	Crisis Response Team	Added prior to March 2003
CRT	Contract Review Team	May 07, 2014
CRUD	Creation, Retrieval, Updating, and Deletion	July 15, 2004
CS	Controlled Substances	July 15, 2004
CS	Compensation Services	April 30, 2014
CS	Cost Sharing	May 12, 2010
CS	Common Service	April 11, 2007
CS	Caregiver Support	May 19, 2015
CSA	Common Services Architecture	July 15, 2004

CSAC	Certified Substance Abuse Counselor	October 25, 2006
CSC	Caregiver Support Coordinator	December 21, 2011
CSCA	Contractor Security Control Assessment	July 05, 2011
CSCIS	Computer Software Configuration Items	July 28, 2004
C-SCOPE	Colonoscopy	April 23, 2014
CSCS	Computer Software Components	July 28, 2004
CSE	Customer Service Environment	Added prior to March 2003
CSEMO	Corporate Senior Executive Management Office	October 14, 2010
CSF	Common Security Framework	April 23, 2014
CSF	Critical Success Factors	July 15, 2004
CSI	Clinical Specific Improvements	October 05, 2009
CSL	Customer Service Liaison	December 14, 2016
CSM	circulation sensation movement	August 04, 2014
CSN	Category Stock Number	December 15, 2016
CSNF	CONTRACT SKILLED NURSING FACILITY	November 18, 2015
CSNTC	Compensation Service National Training Curriculum	December 14, 2016
CSO	Cyber Security Office	Added prior to March 2003
CSP	Cooperative Studies Program	July 15, 2004
CSP	Cyber Security Professional	April 27, 2004
CSP	Credential Service Provider	October 21, 2014
CSPIVR	Clear or Set Personal Identification Verification Required	December 15, 2016
CSR	Continuous Survey Readiness	October 20, 2010
CSRA	Civil Service Reform Act	Added prior to March 2003
CSRDF	Civil Service Retirement and Disability Fund	January 20, 2011
CSRS	Civil Service Retirement System	July 06, 2010
CSS	Cascading Style Sheet	January 11, 2005
CSST	Capability Specialized Support Team	May 07, 2014
CSSU	Clinical Services Support Unit	September 20, 2010
CST	Collaboration Strategies Team	December 14, 2016
CSUM	Common Security User Manager	July 15, 2004
CSV	Code Set Versioning	July 28, 2003
CSWRI	Center for the Study of War Related Injuries	August 26, 2004
CSWS	COMMUNITY SOCIAL WORK SUPERVISOR	November 18, 2015
CT	claims tracking	December 15, 2016
CT	claims tracking	December 15, 2016
CT	Component testing	April 17, 2015
CT	Commercial Technology	August 17, 2004
CT	Computerised Tomography	July 06, 2009
CT	Computed Tomography	April 13, 2010
CT OR CT SCAN	Computerized tomography (CT scan)	August 14, 2014

CTA	clear to auscultation	January 12, 2009
CTA	Chief Technical Analyst	April 18, 2014
CTAB	Clear To Auscultation Bilaterally	January 04, 2012
CTAP	Career Transition Assistance Plan	November 04, 2009
CTBIE	Comprehensive Traumatic Brain Injury Evaluation	April 03, 2014
CTF	Chloracne Task Force	Added prior to March 2003
CTI	Computer/Telephone Integration	Added prior to March 2003
CTI	Category Type Item	January 23, 2007
CTI	Critical Time Intervention	October 31, 2011
CTO	Chief Technology Officer	July 15, 2004
CTOP	competency, training, orientation, performance	December 03, 2014
CTR	Congressional Tracking Report	April 21, 2016
CTS	Contingency Tracking System	June 30, 2005
CTVHCS	CENTRAL TEXAS VETERANS HEALTH CARE SYSTEM	August 16, 2005
CUI	Concept Unique Identifier	July 15, 2004
CUPS	Customer User Provisioning System (CUPS)	January 15, 2009
CURR	Center for Unit Records Research	July 15, 2004
CUSS	Clinical Utilization Statistical Summary Report	June 25, 2014
CV	Cost Variance	July 22, 2003
CVA	Cerebral vascular accident	August 14, 2014
CVA	costovertebral angle	August 14, 2014
CVC	Central Venous Catheter	September 27, 2010
CVI	converged virtualization infrastructure	December 15, 2016
CVIX	Centralized VistA Imaging Exchange	October 22, 2009
CVS	Conformance Validation Statement	April 23, 2014
CVSO	County Veteran's Service Officer	April 18, 2014
CVT	CLINICAL VIDEO TELEHEALTH	November 17, 2011
CWAD	Crisis Notes, Warning Notes, Allergies and Directives	Added prior to March 2003
CWINRS	Corporate Waco-Indianapolis-Newark-Roanoke-Seattle	April 23, 2014
CWM	Common Warehouse Meta-model	July 15, 2004
CWS	Contract Writing System	March 01, 2010
CWT/IT	Compensated Work Therapy/Incentive Therapy	Added prior to March 2003
CWTS	Cross Word Training System	June 21, 2010
CWV	Center for Women Veterans	October 22, 2015
CX	cancelled	October 21, 2014
CXR	chest x-ray	August 04, 2014
CY	Calender Year	May 12, 2010
D		top
D&F	Determination and Finding	May 12, 2010
D&PPM	Drug & Pharmaceutical Products Management	Added prior to March 2003

D/C	Discontinue Medication	June 10, 2010
D/CED OR D/C	Discharge	July 20, 2011
D/D	DNR/DNI	February 10, 2004
D/L	Download	July 15, 2004
D/T	due to	April 17, 2014
D2D	Digits-to-Digits	April 23, 2014
DA	Drug Accountability/Inventory Interface	December 11, 2007
DAA	Designated Accreditation Authority	October 06, 2011
DAA	Designated Approval Authority	June 30, 2003
DABMSP	Diplomate American Board Multiple Specialties in Podiatry	January 15, 2009
DAC	Discretionary Access Control	July 15, 2004
DACA	Distributed Access Control and Authorization	Added prior to March 2003
DAD	Decision Assessment Document	May 08, 2008
DAEO	Designated Agency Ethics Official	June 27, 2011
DAIC	Division of Audits and Internal Controls	April 23, 2014
DAIS	Development and Infrastructure Support	July 15, 2004
DALC	Denver Acquisition and Logistics Center	April 27, 2009
DAO	Data Access Object	November 22, 2004
DAP	Digital Analytics Program	August 22, 2015
DAR	Designated Agency Representative	April 21, 2016
DAR	Data Architecture Repository	March 31, 2010
DARPA	Defense Advanced Research Projects Agency	March 31, 2010
DART	Data Access Request Tracker	October 12, 2010
DAS	Data Architecture Subcommittee	March 31, 2010
DAS	Deputy Assistant Secretary	Added prior to March 2003
DAS	Data Access Service(s)	February 06, 2015
DASD	Direct Access Storage Device	March 31, 2010
DASHO	Designated Agency Safety and Health Official	Added prior to March 2003
DAT	Digital Audio Tape	July 15, 2004
DAT	Domain Action Team	December 14, 2005
DAV	Disabled American Veterans	Added prior to March 2003
DBA	Data Base Administrator	Added prior to March 2003
DBAC	Deep Bleeder Acoustic Coagulation	April 03, 2006
DBAT	Desktop Baseline Assessment Toolkit	December 14, 2016
DBC	Disruptive Behavior Committee	December 13, 2006
DBCT	Data Breach Core Team	March 31, 2010
DBIA	Database Integration Agreement	July 15, 2004
DBIC	Data Base Integration Committee	Added prior to March 2003
DBM	Disruptive Behavior Management	May 03, 2011
DBMS	Database Management System(s)	February 06, 2015
DBMS	Data Base Management System	Added prior to March 2003

DBQ	Disability Benefits Questionnaires	July 20, 2011
DBRS	Data of Breach response Service	December 15, 2016
DBRS	Disruptive Behavior Reporting System	December 15, 2016
DBS	Database Server	December 11, 2007
DBSS	Defense Blood Standard System	Added prior to March 2003
DBT	Dialectical Behavior Therapy (DBT),	April 23, 2014
DC	Data Consortium	March 31, 2010
DC	Domain Controllers	March 31, 2010
DC OR DC'D	discharge or discharged	January 21, 2016
DCA	Delayed Continuing Accreditation	Added prior to March 2003
DCAP-BTLS	Deformities, Contusions, Abrasions, Penetrations, Burns, Tenderness, Lacerations, Swelling	August 11, 2015
DCBE	Double Contrast Barium Enema	December 14, 2010
DCC	Deputy Chief Counsel	April 21, 2016
DCD	Data Collection Division	December 15, 2016
DCE	Distributed Computing Environment	July 15, 2004
DCEP	Data Collection and Extraction Program	July 30, 2015
DCFSA	Dependent Care Flexible Spending Account	March 31, 2010
DCHV	Domiciliary Care for Homeless Veterans	November 24, 2010
DCIA	Debt Collection Improvement Act	March 31, 2010
DCIO	Deputy Chief Information Officer	July 15, 2004
DCM	Department Cost Manager	Added prior to March 2003
DCMO	Deputy Chief Management Officer	May 07, 2014
DCMS	Document Correspondence Management System	March 19, 2007
DCO	Defense Connect Online	May 07, 2014
DCO	Data Center Operations (Formerly CDCO)	April 17, 2014
DCOM	Distributed Component Object Model	July 15, 2004
DCPS	Defense Civilian Pay System	February 18, 2010
DCR	Design Change Requirement	April 20, 2010
DD	Desired Date	October 21, 2011
DD	Data Dictionary	July 15, 2004
DD&R	Document Development and Review	September 08, 2011
DD214	Defense Department 214	December 15, 2016
DDC	Denver Distribution Center	Added prior to March 2003
DDCSS	Drug Dependence Clinical Support System	Added prior to March 2003
DEA	Drug Enforcement Administration	October 20, 2011
DEA	Dependents Educational Assistance	July 30, 2015
DEC	Dental Education Center	Added prior to March 2003
DECC	Defense Enterprise Computing Center	June 12, 2003
DEERS	Defense Enrollment and Eligibility Reporting System	April 11, 2003

DEMO	Disability Examination Management Office	December 08, 2010
DEMPS	Disaster Emergency Medical Personnel System	Added prior to March 2003
DENTT	Disability Evaluation Narrative Text Tool	December 21, 2011
DEP	Delayed entry program	December 15, 2016
DEPSECDEF	Deputy Secretary of Defense	May 07, 2014
DEPSECVA	Deputy Secretary	January 29, 2009
DES	Disability Evaluation System	November 25, 2008
DES	Dental Encounter System	December 11, 2007
DES	Digital Encryption Standard	July 15, 2004
DEU	Delegated Examining Unit	October 22, 2008
DFAR	Defense Federal Acquisition Regulation	May 07, 2014
DFAS	Defense Finance and Accounting System	February 02, 2009
DFC	Discharge From Clinic	Added prior to March 2003
DFI	Document, Forms, & Images	October 02, 2007
DFN	Data File Number	July 15, 2004
DFO	Director of Field Operations	October 05, 2009
DFS	Distributed File System	September 04, 2015
DGB	Data Governance Board	February 18, 2010
DGC	Data Governance Council	June 14, 2011
DHCP	Dynamic Host Control Protocol	January 25, 2005
DHCP	Decentralized Hospital Computer Program	Added prior to March 2003
DHHS	Department of Health and Human Services	Added prior to March 2003
DHIMS	Defense Health Information Management System	April 23, 2014
DHMSM	DoD Health Management System Modernization	April 23, 2014
DHPO	Distance Health Program Office	April 23, 2014
DHT	Dobhoff tube	February 27, 2006
DI	Diabetes insipidus	September 23, 2014
DIACAP	DoD Information Assurance Certification and Accreditation Process	April 23, 2014
DIB	Data Integrity Board	Added prior to March 2003
DIC	Dependency and Indemnity Compensation	Added prior to March 2003
DICOM	Digital Imaging and Communications in Medicine	Added prior to March 2003
DID	Data Item Description	May 12, 2010
DIGA	Diabetic Intensive Group Appointment	April 23, 2014
DIGMA	Drop-In Group Medical Appointment	October 03, 2005
DIMHRS	Defense Integrated Military Human Resources System	March 19, 2009
DIRT	DIAGNOSTIC IMAGING RADIOLOGICAL IMAGING	April 30, 2014
DISA	Defense Information Systems Administration	Added prior to March 2003
DIT	Development Integration Testing	Added prior to March 2003
DIT	Domain Implementation Team	December 14, 2005
DIV	Data and Information View	April 23, 2014
DJD	Degenerative Joint Disease	November 06, 2007

DKA	Diabetic Ketoacidosis	May 19, 2015
DL	Distribution List	August 16, 2011
DLL	dynamic link library	July 30, 2015
DLO	Designated Learning Officer	October 14, 2008
DLP	Date Last Paid	December 14, 2016
DM	diabetis Melitis	September 23, 2014
DM	Diabetes	April 25, 2011
DM	Diversity Management	July 15, 2004
DMA	Department of Memorial Affairs	May 01, 2014
DMA	Disability and Medical Assessment	April 23, 2014
DMC	Debt Management Center	Added prior to March 2003
DMDC	Defense Manpower Data Center	Added prior to March 2003
DME	Development/Maintenance/Enhancement	Added prior to March 2003
DME	Development, Maintenance, and Enhancement	April 23, 2014
DME	Durable Medical Equipment	December 12, 2014
DME	Development, Modernization and Enhancements	March 31, 2009
DME	Durable Medical Equipment	February 18, 2010
DME	Diabetic Macular Edema	December 22, 2005
DMED	Defense Medical Epidemiology Database	October 29, 2003
DMI	Data Migration Initiative	July 12, 2006
DMII	Diabetes Mellitus Type 2	June 08, 2010
DMIM	Domain Message Information Model	March 07, 2008
DMIM	Defense Medical Information Management	Added prior to March 2003
DMIX	Defense Medical Information Exchange	April 23, 2014
DMLSS	Defense Medical Logistics Standard Support	Added prior to March 2003
DMLT	Division Leadership and Management Training (DMLT)	April 23, 2014
DMMS	Decentralized Medical Management System	Added prior to March 2003
DMMSC	Defense Medical Systems Support Center	Added prior to March 2003
DMO	Directives Management Officer	Added prior to March 2003
DMO	Data Management Organization	April 21, 2016
DMRIS	Defense Medical Regulating Information System	Added prior to March 2003
DMS	Document Management System	May 05, 2010
DMSS	Defense Medical Surveillance System	July 28, 2003
DMU	Dataless Management Utility	July 15, 2004
DMV	Department of Motor Vehicles	June 16, 2015
DMZ	Demilitarized Zone	July 15, 2004
DNBI	Lowest Disease to Non-Battle Injury	April 11, 2007
DNR	Do Not Respond	Added prior to March 2003
DNR	Do Not Resuscitate	Added prior to March 2003
DNS	Domain Name Server or Domain Name System	Added prior to March 2003

DNS	Deviated Nasal Septum	March 08, 2010
DNVF	Distal NeuroVascular Function	February 06, 2015
DNVFI	Distal NeuroVascular Function Intact	February 06, 2015
DO	Delivery Order	Added prior to March 2003
DOA	Date of Access	April 17, 2014
DOB	Date of Birth	June 09, 2008
DOBI	Department of Defense Instruction	May 12, 2010
DOC	Department Operations Council	May 04, 2006
DOC	Date of Claim	April 17, 2015
DoD	Department of Defense	Added prior to March 2003
DODAF	Dept. of Defense Architecture Framework	April 18, 2014
DODAF	Dept. of Defense Architectural Framework	April 23, 2014
DOE	Department of Energy	July 15, 2004
DOE	Dyspnea on Exertion	December 22, 2005
DOE	Dyspenic on exertion	December 15, 2016
DOEHDR	Defense Occupational Exposure Health Data Repository	July 26, 2004
DOI	DATE OF INJURY	December 15, 2016
DOJ	Department of Justice	July 15, 2004
DOL	Department of Labor	Added prior to March 2003
DOLAP	Desktop On-Line Analytical Processing	July 15, 2004
DOMP	Delivery Order Management Plan	Added prior to March 2003
DOORS	Dynamic Object Oriented Requirements System	June 03, 2005
DOORS	Distribution of Operational Resources System	June 27, 2011
DORS	Department Of Rehabilitation Service	Added prior to March 2003
DoS	Denial-of-Service	February 02, 2011
DOT	Department of Transportation	July 15, 2004
DPC	Drug Program Coordinator	Added prior to March 2003
DPC	Data Processing Center	December 15, 2016
DPDB	Division of Practitioner Data Banks	Added prior to March 2003
DPEO	Deputy Program Executive Officer	January 09, 2006
DPOA	Durable Power of Attorney	April 23, 2014
DPRIS	Defense Personnel Records Image Retrieval System	March 02, 2009
DPU	Discharge Placement Unit	June 10, 2010
DQA	Division of Quality Assurance	Added prior to March 2003
DQDB	Distributed Queue Dual Bus	July 15, 2004
DQM	Data Quality Monitoring	November 24, 2010
DQS	Data Quality Service	October 04, 2010
DR	Data Repository	July 15, 2004
DRAS	Disability Rating Activity Site	December 15, 2016
DRE	Digital Rectal Exam	September 23, 2014
DRG	Diagnosis Related Group	Added prior to March 2003

DRM	Dental Record Manager	Added prior to March 2003
DRMO	Division Records Management Officer	October 22, 2015
DRMROL	Deployment Related Medical Record Online	July 28, 2003
DRO	Decision Review Officer	July 15, 2004
DRP	Disaster Recovery Plan	April 10, 2014
DRP	Disaster Recovery Plan	April 23, 2014
DRR	Division of Research Resources	Added prior to March 2003
DRRTTP	Domiciliary Residential Rehabilitation Treatment Program	April 06, 2006
D-RRTP	Domiciliary Residential Rehabilitation and Treatment Programs	December 14, 2010
DRS	Dispute Resolution Specialist	February 13, 2006
DRSG	dressings, as in wound coverage	July 25, 2014
DRSG	Dressing	July 18, 2014
DRSG	Dressing, as in wound coverage	July 25, 2014
DS	Data Standardization	January 30, 2006
DS	Delivery Services	March 23, 2007
DS3	Disabled Soldier Support System	June 03, 2004
DSAP	Domiciliary Substance Abuse Program	December 14, 2016
DS-ASC	Data Security - Assessment and Strengthening of Controls	June 21, 2010
DSCC	Documentation Standards and Conventions Committee	Added prior to March 2003
DSCM	Data Standardization Configuration Management (Board)	Added prior to March 2003
DSCMB	(DoD) Data Standards Configuration Management Board	Added prior to March 2003
DSCU	Dementia Specialty Care Unit	April 15, 2014
DSI	Data Sharing Interface (Currently BHIE)	October 04, 2004
D-SIDDOMS II	Defense Medical Information Management/Systems Integration, Design, Development, Operations and Maintenance Services II (DoD related)	Added prior to March 2003
DSM	Diagnostic and Statistical Manual of Mental Disorders (DSM-III)	Added prior to March 2003
DSM	Digital Standard Mumps	Added prior to March 2003
DSM	Diagnostic and Statistical Manual of Mental Disorders	Added prior to March 2003
DSMB	Data Safety Monitoring Board	March 18, 2009
DSO	Decision Support Office	July 10, 2007
DSO	Decision Support Objects	Added prior to March 2003
DSOB	Data Standardization Oversight Board	June 28, 2004
DSOIRM	Designated Senior Official for IRM	Added prior to March 2003
DSS	Document Storage Systems	Added prior to March 2003
DSS	Demo Sites Subgroup	July 27, 2006
DSS	Decision Support Systems	April 15, 2010
DSS ROI	Data Storage System, Inc Record of Information	October 16, 2008
DSVT	Data Submission and Validation Tool	February 18, 2010
DT&E	Development Test & Evaluation	Added prior to March 2003
DTA	Data Transfer Agreement	January 12, 2012

DTAC	Development Technology Advisory Committee	October 01, 2003
DTAP	Disability Transition Assistance Program	July 15, 2004
DTC	Day Treatment Center	Added prior to March 2003
DTC	Development and Test Center	May 07, 2014
DTC	Development and Test Center	May 07, 2014
DTD	Document Type Definition	Added prior to March 2003
DTE	Development and Test Environment	April 18, 2014
DTP	Data Transfer Program	July 15, 2004
DTS	Document Tracking System (OCIO controlled correspondence)	Added prior to March 2003
DTV	Digital Television	Added prior to March 2003
DUNS	Data Universal Numbering System	May 12, 2010
DUR	Drug Utilization Review	Added prior to March 2003
DURSA	Data Use and Reciprocal Support Agreement	May 07, 2009
DUSB	Deputy Undersecretary for Benefits	December 15, 2008
DUSH	Deputy Under Secretary for Health	April 11, 2007
DUSHOM	Deputy Under Secretary for Health for Operations and Management (10N)	November 18, 2003
DUV	Dual Use Vehicle	December 14, 2016
DUZ	Designated User	June 04, 2009
DVA	Department of Veterans Affairs	December 15, 2016
DVA	Dishonorable for VA Purposes	February 06, 2015
DVEIVR	DVEIVR	April 23, 2014
DVT	Deep Vein Thrombosis	July 30, 2015
DX	Diagnosis or disease	August 04, 2014
E		top
E&F	Enrollment and Forecasting	March 24, 2011
E&IT	Electronic & Information Technology	April 15, 2010
E&M CODES	Evaluation and Management Codes	April 23, 2014
E/M	evaluation and management	August 30, 2011
E/R	Entity Relationship	July 15, 2004
E3R	Electronic, Error and Enhancement Report	Added prior to March 2003
EA	Enterprise Architecture	Added prior to March 2003
EAA	Employment Adjustment Allowance	September 23, 2014
EAC	Enterprise Architecture Council	Added prior to March 2003
EAC	Estimate At Completion	July 22, 2003
EAJA	Equal Access to Justice Act	September 04, 2015
EAM	Enterprise Asset Management	February 06, 2015
EAP	Employee Assistance Program	April 23, 2014
EAS	Environmental Agents System	October 25, 2011
EAS	Employee Accountability System	June 27, 2011

EAS	External Assessment Services	April 23, 2014
EASR	Enterprise Architecture Segment Report	August 12, 2009
EB	Executive Board	Added prior to March 2003
EBAC	Entity-Based Access Control	July 15, 2004
EBB	Executive Briefing Book	March 15, 2004
EBDI	Enterprise Business and Data Integration	April 23, 2014
EBE	Enterprise Backup with Encryption	May 10, 2010
EBERS	Enhanced Biomedical Engineering Resource Survey	October 30, 2014
EBF	Entity Business Function	July 15, 2004
EBN	eBenefits	October 25, 2011
EBP	Evidence-Based Psychotherapy	November 18, 2010
EBRI	Employee Benefit Research Institute	March 31, 2010
EBS	Enterprise Business Strategies	July 15, 2004
EBUS	Endobronchial Ultrasound	April 23, 2014
EC	Electronic Commerce	July 15, 2004
EC	Ethics Consultation	April 23, 2014
EC	Emerging Care	Added prior to March 2003
EC	Event Capture	Added prior to March 2003
EC CCB	Emergency Care Change Control Board	Added prior to March 2003
EC PAT	Ethics Consultation Proficiency Assessment Tool	April 23, 2014
ECAP	Enrollment Certification Automated Processing	July 15, 2004
ECAR	Electronic Computer Access Request	May 19, 2015
ECAT	Electronic Catalog	Added prior to March 2003
ECC	Ethics Consultation Coordinator	April 23, 2014
ECCF	Enterprise Conformance and Compliance Framework	April 23, 2014
ECCO	Essentials of Critical Care Orientation	December 01, 2006
ECF	Executive Career Field	October 04, 2005
ECF	Extended Care Facility	October 02, 2007
ECFCDP	Executive Career Field Career Development Program	October 11, 2007
ECFT	Electronic Case File Transfer	April 23, 2014
ECG	Electrocardiogram	November 22, 2004
ECHO	Echocardiogram	June 21, 2010
ECM	Energy Conservation Measures	December 02, 2011
ECM	Education Case Manager	July 15, 2004
ECM	Essentials of Clinical Medicine	January 21, 2016
eCME	Electronic Claims Management Engine	April 13, 2010
ECMO	Extracorporeal Membrane Oxygenation	December 20, 2005
ECMS	Electronic Contract Management System	April 13, 2010
ECOE	Epilepsy Centers of Excellence	December 15, 2016
ECOG	ECOG Performance Status	April 15, 2014
ECP	Engineering Change Proposals	Added prior to March 2003

ECQAC	Extended Care Quality Assurance Committee	April 21, 2016
ECR	Executive Conference Room	February 04, 2010
ECS	Event Capture System	May 30, 2007
ECS	Enterprise Class Storage	May 10, 2010
ECS	Ethics Consultation Service	April 23, 2014
ECS	Enterprise Cybersecurity Strategy	January 21, 2016
ECSBAP	Enterprise Cyber Security Business Assurance Program	July 15, 2004
ECSIP	Enterprise Cyber Security Infrastructure Project	Added prior to March 2003
ECSS	Education Compliance Survey Specialist	July 15, 2004
ECST	Enterprise Cybersecurity Strategy Team	January 21, 2016
ECT	Electroconvulsive Therapy	April 23, 2014
ECTM	Executive Chief Technology Manager	April 23, 2014
ED	Emergency Department	August 22, 2011
ED&T	Employee Development and Training	July 15, 2004
EDAS	Enterprise Data Architecture Services	October 04, 2010
EDB	Enrollment Database	Added prior to March 2003
EDD	Electronic Data Dictionary	Added prior to March 2003
EDE	(Enterprise Development Environment	April 23, 2014
EDI	Electronic Data Interchange	Added prior to March 2003
EDI PN ID	Electronic Data Interface Person Identifier (DoD term)	November 07, 2007
EDI /MRA	Electronic Data Interchange/Medical Reform Act	Added prior to March 2003
EDI /MRA	Electronic Data Interchange/Medicare Remittance Advice	Added prior to March 2003
EDI_PN_IDS	electronic data interface person identifiers	July 11, 2007
EDIFACT	Electronic Data Interchange Fir Administration, Commerce, and Transport	July 15, 2004
EDIPI	(DoD's) Electronic Data Interchange Personal Identifier	August 12, 2010
EDIS	Emergency Department Information System	March 07, 2011
EDM	Executive Decision Memorandum	May 08, 2003
EDMS	Electronic Data Management System	Added prior to March 2003
EDO	Emergency Detention Order	January 21, 2016
EDP	Electronic Data Processing	July 15, 2004
EDR	Event Driven Reporting	Added prior to March 2003
EDR	Educational Data Repository	April 17, 2014
EDR	Education Data Repository	April 23, 2014
EDRP	Exercise Disaster Recovery Plan	October 30, 2014
EDRP	Education Debt Reduction Program	July 30, 2015
EDS	Electronic Data Systems	Added prior to March 2003
EDSS	Expanded Disability Status Scales	Added prior to March 2003
EDW	Enterprise Data Warehouse	July 15, 2004
EE	External Environment	July 15, 2004

EEG	Electroencephalogram	March 24, 2011
EELS	Enterprise Exception Log Service	August 28, 2008
EEO	Equal Employment Opportunity	Added prior to March 2003
EEOB	Electronic Explanation Of Benefits	January 04, 2012
EEOC	Equal Employment Opportunity Commission	May 12, 2010
EES	Employee Education System	Added prior to March 2003
EEU	Enterprise Exchange Upgrade	May 10, 2010
EF	ejection fraction	May 19, 2015
EFAV	Enhanced Failsoft Access for VISTA	Added prior to March 2003
EFDA	Expanded Function Dental Auxiliaries	Added prior to March 2003
EFFECT	ER Frequent Flyer; Education, Coordination & Timely Treatment	May 02, 2007
EFT	Electronic Funds Transfer	February 13, 2006
EGT	Enrollment Group Threshold	July 15, 2004
EGUI	electronic Graphical User Interface	May 07, 2014
EHBD	Enterprise Health Benefits Determination	October 21, 2014
EHCPM	Enrollee Health Care Projection Model	March 26, 2009
EHISN	eHealth Information Support Network	February 18, 2010
EHMP	Enterprise Health Management Platform	December 03, 2014
EHPDP	Employee Health Promotion Disease Prevention	March 15, 2010
EHR	Electronic Health Record	Added prior to March 2003
EHRA	Electronic Health Record Architecture	July 15, 2004
EHRI	Electronic Health Records Interoperability	Added prior to March 2003
EHRI	Enterprise Human Resources Integration	August 17, 2011
EHRP	Electronic Health Records Plan	Added prior to March 2003
EHR-S	Electronic Health Record System	October 27, 2009
EHRS-FM	Electronic Health Record System - Functional Model	May 27, 2016
EHRWA	Electronic Health Record Way Ahead	May 07, 2014
EHRWG	Electronic Health Record Working Group	May 17, 2004
EHT	Emerging Health Technologies	March 07, 2008
EHTAC	Emerging Health Technology Advancement Center	May 28, 2009
EHX	eHealth Exchange	January 21, 2016
EIB	Enterprise Information Board	March 20, 2003
EIC	Electronic Information Carrier	October 18, 2005
EIC	Executive in Charge	February 06, 2015
EIE	Enterprise Infrastructure Engineering (See ESE as of 12/10)	December 01, 2010
EIL	Equipment Inventory Listing	Added prior to March 2003
EIN	Employer Identification Number	Added prior to March 2003
EIS	Executive Information Systems	July 15, 2004
EIS	Enterprise Infrastructure Support	December 15, 2016
EISA	Extended Industry Standard Architecture	February 02, 2006
EISWG	Enterprise Information Systems Work Groups	December 02, 2003

EIV	Electronic Insurance Verification	April 15, 2010
EJB	Enterprise JavaBean	October 01, 2003
EKG	Electrocardiogram	July 15, 2004
EL	Ethical Leadership	April 23, 2014
ELB	Executive Leadership Briefing	March 03, 2009
ELC	Executive Leadership Conference	December 01, 2006
ELC	Ethical Leadership Coordinator	April 23, 2014
ELISA	Enzyme Linked Immunosorbent Assays	Added prior to March 2003
ELMS	Equipment Lease Management Service	October 22, 2015
ELNEC	End-of-Life Nursing Education Consortium	May 07, 2014
ELR	Education Liaison Representatives	September 23, 2014
ELT	Executive Leadership Team	March 01, 2011
EMC	Enterprise Management Committee	Added prior to March 2003
EMC	Enterprise Management Concept	Added prior to March 2003
EMDR	Eye Movement Desensitization and Reprocessing	April 30, 2014
EME	Electronic Medical Evidence	July 20, 2005
EMFSO	Engineering Management and Field Support Office	Added prior to March 2003
EMG	Electromyography	March 23, 2015
EMI	Electromagnetic Interference	July 15, 2004
EMI	Enterprise Messaging Infrastructure	September 23, 2014
EMM	Enterprise Mobility Management	March 23, 2015
EMME	Engineering Acquisition Materiel Management & Equipment	Added prior to March 2003
EMPB	Emergency Mobilization Preparedness Board	Added prior to March 2003
EMPI	Enterprise Master Patient Index	July 15, 2004
EMR	Electronic Medical Record	Added prior to March 2003
EMRA	Electronic Medicare Remittance Advice - ANSI X12 835	July 27, 2009
EMRSS	Emergency Management and Resource Sharing Service	Added prior to March 2003
EMS	Environmental Management Service	January 11, 2005
EMS	Emergency Medical Services	March 23, 2015
EMSHG	Emergency Management Strategic Healthcare Group	Added prior to March 2003
EMT	Executive Management Team	Added prior to March 2003
ENT	Ear Nose & Throat	April 17, 2014
ENTSR	Enterprise Service Request Schema	June 02, 2006
EO	Enterprise Operations	May 07, 2014
EO	Executive Order	July 15, 2004
EOAM	End of Accounting Month	October 01, 2003
EOB	Explanation of Benefits	September 12, 2007
EOC	Emergency Operations Center	September 12, 2006
EOC	Environment of Care	June 23, 2008
EOC	Episode of Care	Added prior to March 2003

EOD	Entered On Duty	August 04, 2008
EOFD	Enterprise Operations and Field Development	December 21, 2010
EOL	end of life	March 23, 2015
EOM	End of Month	April 27, 2009
eOPF	electronic Official Personnel Folder	April 14, 2009
EP	Expert Panel	Added prior to March 2003
EP	End Product	April 23, 2014
EPA	Environmental Protection Agency	Added prior to March 2003
EPAS	Electronic Permission Access System	February 06, 2015
EPCS	Electronic Prescriptions for Controlled Substances	May 07, 2014
EPER	electronic patient event reporting	December 15, 2016
EPG	Enterprise Process Group	April 11, 2007
EPHI	electronic Personal Health Information	June 11, 2014
EPHRA	EOB Payment Healthcare Remittance Advice	November 15, 2010
EPI	Emerging Pathogens Initiative	Added prior to March 2003
EPIC	Electronic Privacy Information Center	May 01, 2014
EPIP	Existing Product Intake Program	April 21, 2016
EPIR	Electronic Performance Improvement Record	June 22, 2015
EPM	Electronic Performance Measurement	December 10, 2014
EPM	Enterprise Project Management	Added prior to March 2003
EPMO	Office of Information and Technology Enterprise Program Management Office	May 28, 2016
EPMS	Enterprise Project Management Software	Added prior to March 2003
EPP	Enterprise Privacy Program	April 27, 2004
EPR	Electronic Patient Record	Added prior to March 2003
EPRI	Electronic Patient Record Interface	Added prior to March 2003
EPRP	External Peer Review Program	August 25, 2011
EPS	Enterprise Project Structure	January 11, 2011
EPS	Enterprise Product Support	August 06, 2007
EPTS	Existing Prior To Service	December 03, 2009
EQ	emotional intelligence quotient	April 23, 2014
E-QIP	Electronic Questionnaires for Investigations Processing	November 17, 2011
ER	Emergency Room or Emergency Department	August 14, 2014
ER	Electronic Record	Added prior to March 2003
ER7	Encoding Rules Seven	April 15, 2010
ERA	Electronic Remittance Advice	April 01, 2008
ERANGE	Enhance Rural Access Network for Growth Enhancement	July 20, 2011
ERC	Executive Resources Council	December 15, 2016
ERCP	Endoscopic Retrograde Cholangiopancreatography	October 21, 2014
ERF	Enterprise Systems Engineering (ESE) Request Form	January 21, 2016
ERM	Enterprise Risk Management	April 03, 2014

ERMIS	External Review Management Information System	Added prior to March 2003
ERRA	Examination Request Routing Assistant	July 30, 2015
ERT	Enterprise Reference Terminology	Added prior to March 2003
ERX	Electronic Prescription	June 21, 2010
ES	Employment Specialist	December 14, 2016
ES	Enterprise Strategy	July 15, 2004
ES	Environmental Services	December 14, 2016
ES	Enrollment System	January 21, 2016
ESA	Enterprise Systems Architecture	January 10, 2006
ESB	Enterprise Service Bus	August 27, 2007
ESCCB	Enterprise Security Change Control Board	February 16, 2006
ESCI P	Enterprise Cyber Security Infrastructure Project	September 24, 2004
ESDD	Enterprise Solution Design Document	January 21, 2016
ESE	Enterprise Systems Engineering	December 01, 2010
ESG	Environmental Support Group	Added prior to March 2003
ESLD	End Stage Liver Disease	September 05, 2011
ESM	Enterprise Systems Management	Added prior to March 2003
ESMC	Enterprise System Management Committee	Added prior to March 2003
ESPD	Electronic Support for Patient Decisions	May 24, 2004
ESR	Enrollment System Redesign	March 23, 2007
ESRD	End Stage Renal Disease	November 04, 2009
ESS	Enterprise Support Solution	Added prior to March 2003
ESSENCE	Electric Surveillance System for the Early Notification of Community-based Epidemics	October 18, 2007
ESSS	VA Enterprise Security Solution Service	January 20, 2011
EST	Eastern Standard Time	October 21, 2011
EST	Enterprise System Testing	May 08, 2014
ETA	Enterprise Technical Architecture	April 18, 2014
ETA	Edifecs Transaction Management/Analysis Tool	October 25, 2011
ETA	Enhanced Time and Attendance System	June 27, 2011
ETA	Estimated Time of Arrival	November 30, 2007
ETC	Estimate To Completion	July 22, 2003
ETC	Engineering Training Centers	Added prior to March 2003
ETC	Education and Training Center (for engineering and construction management)	Added prior to March 2003
ETCS	Electronic Transactions and Code Sets	Added prior to March 2003
ETL	Extract, Transform and Load	November 30, 2009
ETMR	Electronic Theater Medical Record	Added prior to March 2003
ETOH	Ethanol, also called ethyl alcohol, pure alcohol, grain alcohol, or drinking alcohol	August 04, 2014
ETOH	Abbreviation for ethyl alcohol. Per MediLexicon.com	August 04, 2014

ETR	Estimated Time of Restoration	April 09, 2014
ETS	Enterprise Tactical Support	Added prior to March 2003
ETS	Enterprise Terminology Services	October 22, 2003
ETS	Enterprise Testing Service	July 06, 2009
ETS	End Time in Service	April 21, 2016
EUD	External Urinary Device	February 06, 2015
EUL	Enhanced Use Lease	August 19, 2010
EUROREC	European Institute for Health Records	December 15, 2008
EV	Earned Value	July 15, 2004
EVA	Electronic VA	Added prior to March 2003
EVEAH	Enhance the Veteran Experience and Access to Healthcare	March 24, 2011
EVH	Eliminate Veterans Homelessness	April 23, 2014
EVMS	Earned Value Management System	July 22, 2003
EVN	Enterprise Video Network	May 07, 2014
EVR	Eligibility Verification Report	March 15, 2010
EVS	Enterprise Vista Support	January 25, 2005
EVSS	Enterprise Veterans Self Service Portal Platform	April 17, 2014
EVTN	Enterprise Video Teleconferencing Network	April 23, 2014
EWIS	Enterprise Web Infrastructure Support	March 21, 2014
EWL	Electronic Wait List	September 28, 2005
EXP	Expiratory, as in lung sound assessment	August 14, 2014
EXS	Exchange Server Support	August 22, 2011
F		top
F/C/S	Fever Chills Sweats	April 17, 2015
F/U	follow up	October 21, 2014
F2F	Face-to-Face Meeting	April 09, 2014
FA	Forearm	September 23, 2014
FA	forearm	January 21, 2016
FAADS	Federal Assistance Award Database System	February 18, 2010
FAB	Field Advisory Board	Added prior to March 2003
FACA	Federal Advisory Committee Act	September 21, 2010
FAC-C	Federal Acquisition Certification in Contracting	February 18, 2010
FACCT	Foundation for Accountability	Added prior to March 2003
FACHE	Fellow in American College of Healthcare Executives	May 07, 2007
FAC-P/PM	Federal Acquisition Certification Program/Project Management	June 21, 2010
FAIN	Federal Award Identifier Number	February 18, 2010
FAM	Financial Audit Manual	September 29, 2010
FAP	Full Account Profile	April 15, 2010
FAP	Fixed Asset Subsystem	April 23, 2014
FAPA	Fellow in the American Psychiatric Association	June 11, 2014

FAQ	Frequently Asked Questions	April 27, 2004
FAR	Federal Acquisition Regulations	Added prior to March 2003
FARC	Federal Archives and Records Centers	June 16, 2015
FAS	Finance and Accounting System	March 15, 2010
FAS	Fiscal Accounting Services	March 15, 2010
FASA	Federal Acquisition Streamlining Act	May 12, 2010
FASAB	Federal Accounting Standards Advisory Board	April 17, 2014
FATKAAT	Fat-Client Kernel Authentication & Authorization Tool	March 14, 2005
FATO	Final Authority to Operate	Added prior to March 2003
FBCS	Fee Basis Claim System	February 25, 2008
FBG	fasting blood glucose	May 19, 2015
FBI	Federal Bureau of Investigation	June 06, 2006
FBS	Fiduciary-Beneficiary System	April 23, 2014
FBS	Fiduciary Beneficiary System	April 23, 2014
FC	Finance Center	Added prior to March 2003
FCA	Facility Condition Assessment	April 21, 2016
FCC	Federal Coordinating Center	December 28, 2011
FCC	Federal Communications Commission	October 31, 2011
FCDM	Financial and Clinical Data	July 21, 2004
FCG	First Consulting Group	Added prior to March 2003
FCG	Functional Capabilities Group	May 07, 2014
FCIO	Facility Chief information Officer	May 07, 2014
FCIO	Facility Chief Information Officer	March 21, 2014
FCIO	Facility Chief Information Officer	April 23, 2014
FCIP	Federal Career Intern Program	October 01, 2008
FCMT	Federal Case Management Tool	November 30, 2009
FCP	Fund Control Point	March 12, 2009
FCP	Federal Credentialing Program	Added prior to March 2003
FCRA	Fair Credit Reporting Act	October 04, 2010
FCW	Federal Computer Week	Added prior to March 2003
FD	Fill Date	April 15, 2010
FDA	Food and Drug Administration	Added prior to March 2003
FDB	First Data Bank	April 23, 2014
FDC	Fully Developed Claims	April 23, 2014
FDCC	Federal Desktop Core Configuration	March 05, 2009
FDCCI	Federal Data Center Consolidation Initiative	December 14, 2010
FDDI	Fiber Distributed Data Interface	March 23, 2007
FDP	Facility Development Plan	Added prior to March 2003
FDS	Field Developed Software	May 08, 2008
FE	Field Examiner	July 21, 2004
FEA	Federal Enterprise Architecture	July 21, 2004

FECA	Federal Employees' Compensation Act	July 21, 2004
FEDRAMP	Federal Risk and Authorization Management Program (FedRAMP)	April 15, 2014
FEDSIM	Federal Systems Integration and Management Center	Added prior to March 2003
FEDSMR	Office of Operations, Security and Preparedness	Added prior to March 2003
FED-STD	Federal Standard	May 12, 2010
FEMA	Federal Emergency Management Agency	Added prior to March 2003
FEPAC	Facility Engineering, Planning and Construction Office	Added prior to March 2003
FERCCA	Federal Erroneous Retirement Coverage Corrections Act	December 01, 2010
FERET	Formal Event Review and Evaluation Tool	May 29, 2007
FERS	Federal Employee Retirement System	April 30, 2007
FFATA	Federal Funding Accountability and Transparency	February 18, 2010
FFB	Franchise Fee Board	May 09, 2011
FFMIA	Federal Financial Management Improvement Act	July 21, 2004
FFP	Fugitive Felon Program	November 01, 2005
FFP	Firm-Fixed-Price	May 12, 2010
FFRDC	Federally Funded Research and Development Center	April 15, 2014
FHA	Federal Housing Administration	July 21, 2004
FHA	Federal Health Architecture	April 11, 2007
FHCC	Federal Health Care Center	April 04, 2008
FHCRS	Federal Health Care Resources Sharing (database)	Added prior to March 2003
FHIE	Federal Health Information Exchange (formerly GCPR)	Added prior to March 2003
FHIL	Federal Health Informatics Leadership	April 15, 2010
FHIL	Field Health Informatics Leadership	March 23, 2015
FHIM	Federal Health Information Model	May 07, 2014
FHIR	Fast Healthcare Interoperability Resources	April 03, 2015
FI	Fiscal Intermediary	Added prior to March 2003
FICAM	Federal Identity, Credential, and Access Management	January 21, 2016
FICWG	Federal Internal Control Working Group	February 22, 2010
FIFO	First in First Out	December 14, 2016
FIM	Functional Independence Measure	March 08, 2010
FIP	Federal Information Processing	Added prior to March 2003
FIPS	Federal Information Processing Standards	Added prior to March 2003
FIPS	Fair Information Practices	January 10, 2011
FIRMAC	Field Information Resources Management Advisory Council	Added prior to March 2003
FIRMR	Federal Information Resources Management Regulations	Added prior to March 2003
FIRP	Federal Individualized Recovery Plan	July 21, 2008
FIRST	Forum of Incident Response and Security Teams	April 23, 2014
FIRSWG	Federal Information Resources Sharing Work Group	Added prior to March 2003
FIS	Field Implementation Services	March 14, 2011
FISCAM	Federal Information System Controls Audit Manual	July 21, 2004

FISI	Facility Infrastructure Standards and Improvement	December 08, 2009
FISMA	Federal Information Security Management Act	April 27, 2004
FISMA	Federal Information Security Modernization Act of 2014	April 21, 2016
FISO	Facility Information Security Officer	March 21, 2014
FIST	Federal Information Sharing Technologies	May 01, 2014
FIT	Financial Innovation and Transformation	April 18, 2014
FITARA	Federal Information Technology Acquisition Reform Act	June 10, 2016
FITSAF	Federal IT Security Assessment Framework	May 21, 2003
FIX	Flow Improvement Inpatient Initiative	January 03, 2007
FL	FAST LETTER	April 03, 2015
FLITE	Financial and Logistics Integrated Technology Enterprise	May 17, 2007
FLM	Front Line Manager	October 21, 2014
FLOPS	Floating Point Operations Per Second	July 21, 2004
FLP	fasting lipid profile	May 19, 2015
FLTCTI	Federal Long Term Care Insurance	Added prior to March 2003
FLTCIP	Federal Long Term Care Insurance Program	November 04, 2009
FM	Functional Model	December 14, 2005
FMEA	Failure Modes and Effects Analysis	December 14, 2016
FMFIA	Federal Managers Financial Integrity Act	July 21, 2004
FMLA	Family and Medical Leave Act of 1993	October 21, 2011
FMOSC	Financial Management Oversight Steering Committee	May 19, 2004
FMS	Facility Management Support	December 01, 2003
FMS	Financial Management System	Added prior to March 2003
FMS	Fecal Management System	June 01, 2010
FNOD	First Notice of Death	March 08, 2010
FO	Field Operations	March 24, 2011
FOB	Fiberoptic Bronchoscopy	April 21, 2016
FOBT	fecal occult blood test	December 21, 2011
FOC	Final Operating Capability	February 09, 2009
FOC	Full Operating Capability	April 23, 2014
FOCAS	Education - Flight, On-the-Job Training, Correspondence, and Apprenticeship System	May 07, 2014
FOD	Field Operations and Development	October 05, 2009
FOEs	Fiscal Notice of Expectations	October 04, 2011
FOH	Federal Occupational Health	June 11, 2003
FOI	Field Office of Investigation	Added prior to March 2003
FOIA	Freedom of Information Act	Added prior to March 2003
FOLA	Fact of Life Adjustment	July 20, 2009
FOR	Foundations of Recovery	October 22, 2015
FORUM	Not an acronym. The national electronic information (e-mail) system	Added prior to March 2003

FOS	Financial Operations Services	July 21, 2004
FOSIM	Family of Services Initiative Management	February 06, 2015
FOUO	For Official Use Only	April 23, 2014
FP	Fixed Price	May 12, 2010
FP	Function Point	December 17, 2007
FPC	Function Point Count	July 21, 2004
FPDS	Federal Procurement Data System	September 20, 2010
FPE	Family Psychoeducation	August 18, 2008
FPIAR	Financial Policy Improvement and Audit Readiness	February 18, 2010
FPIF	FIXED PRICE INCENTIVE FEE	September 04, 2015
FPLOE	Fixed Price Level of Effort	Added prior to March 2003
FPMR	Federal Property Management Regulations	Added prior to March 2003
FPO	Fleet Post Office	September 04, 2015
FPOV	Fee Purpose of Visit	November 08, 2010
FPOW	Former Prisoner of War	January 19, 2010
FPPE	FOCUSED PROFESSIONAL PRACTICE EVALUATION	May 03, 2011
FPPS	Fee Basis Payment Processing System	November 30, 2009
FPS	File and Print Services	April 30, 2014
FQAM	Financial Quality Assurance Manager	January 06, 2010
FQAM	Financail Quality Assurance Manager	October 05, 2009
FQHC	Federally Qualified Health Centers	May 01, 2014
FR	french	June 16, 2015
FR	facility revenue	December 15, 2016
FRC	Federal Recovery Coordinator	August 25, 2009
FRCP	Federal Recovery Coordination Program	August 25, 2009
FRD	Financial Review Division	February 18, 2010
FRD	Functional Requirements Document	Added prior to March 2003
FRI	Friday	August 14, 2014
FRM	Financial Resources Manager	May 05, 2010
FRS	Financial Reports System	July 06, 2010
FRTIB	Federal Retirement Thrift Investment Board	May 01, 2014
FS	Finger Stick	October 10, 2006
FSA-DC	Flexible Spending Account-Dependent Care	July 06, 2010
FSAG	Financial System Advisory Group	Added prior to March 2003
FSA-HC	Flexible Spending Account-Healthcare	July 06, 2010
FSAM	Federal Segment Architecture Methodology	August 12, 2009
FSC	Financial Services Center	February 13, 2006
FSD	Financial Services Division	September 20, 2010
FSFM	File Server File Management	July 21, 2004
FSMB	Federation of State Medical Boards	Added prior to March 2003
FSO	Facility Sustainability Officers	October 22, 2015

FSOD	Functional Status and Outcomes Database	November 22, 2005
FSP	Family Services Program	August 18, 2008
FSR	Financial Status Report - form 5655	May 07, 2014
FSS	Field Security Service	October 25, 2010
FSS	Federal Supply Schedule	May 20, 2004
FSSI OS	Federal Strategic Sourcing Initiative for Office Supplies	October 20, 2010
FST	Functional System Testing	Added prior to March 2003
FTA	Failure to appear	July 25, 2014
FTA	Failure to appear	July 25, 2014
FTAM	File Transfer, Access and Management	July 21, 2004
FTC	Facility Telehealth Coordinator	June 16, 2015
FTC	Federal Trade Commission	December 14, 2016
FTD	Fort Thomas Domicillary	April 21, 2016
FTE	Full-time Equivalent	Added prior to March 2003
FTEE	Full-time Employee Equivalent	Added prior to March 2003
FTI	Federal Tax Information Match	December 14, 2016
FTNGD-OS	Full-Time National Guard Duty for Operational Support	December 08, 2009
FTP	File Transfer Protocol	Added prior to March 2003
FTR	Failed To Report	June 16, 2015
FTS	Folder Tracking System	April 03, 2014
FUO	Fever of Unknown Origin	February 06, 2015
FWIW	For what it's worth	April 21, 2011
FWS	Federal Wage System	August 16, 2011
FWW	Front Wheeled Walker	April 17, 2014
FX	Fracture	August 04, 2014
FX	FUNCTIONAL	December 15, 2016
FY	Fiscal Year	July 21, 2004
FYA	For your action	January 23, 2007
FYFP	FIVE YEAR FACILITY PLAN	December 08, 2016
FYSA	For Your Situational Awareness	May 19, 2015
FYTD	Fiscal Year to Date	April 23, 2014
G		top
G	Gauge	January 21, 2016
G&A	General and Administrative	May 12, 2010
G&L	Gains & Losses	April 20, 2009
G2B	Government to Business	July 21, 2004
G2C	Government to Consumer	July 21, 2004
G2G	Government to Government	July 21, 2004
GAD	General Anxiety Disorder	May 19, 2015
GAF	Global Assessment of Function (score)	Added prior to March 2003

GAGAS	Generally Accepted Government Accounting Standards	February 18, 2010
GAL	Global Address List	March 24, 2011
GAO	Government Accountability Office (Updated 7/04)	July 15, 2004
GAO	General Accounting Office (used BEFORE 7/04)	July 15, 2004
GAPS CENTER	Getting at Patient Safety (GAPS) Center	July 10, 2007
GBC	Government Business Council	April 18, 2014
GBL	Government Bill of Lading	April 17, 2014
GC	General Counsel	August 17, 2009
GCID	Get Corresponding IDs	January 21, 2016
GCM	General Court Martial	December 15, 2016
GCPR or G-CPR	Government-Computer-based Patient Record (See FHIE)	Added prior to March 2003
GCS	Government Consulting Services	Added prior to March 2003
GCS	Glasgow Coma Scale	August 04, 2014
GDIT	General Dynamics Information Technology	February 18, 2010
GDx	Graphical Distribution of VA eXpenditures	June 27, 2011
GEC	Geriatrics and Extended Care	April 27, 2006
GED	General Eligibility Determination	July 21, 2004
GEHA	Government Employees Health Association	April 23, 2014
GEHR	Good Electronic Health Record	July 21, 2004
GEM	Geriatric Evaluation and Management	March 17, 2009
GEMS	Green Environmental Management System	February 04, 2010
GEMS	Green Environmental Management System	January 25, 2006
GERD	gastroesophageal reflux disease	October 22, 2015
GETS	Government Emergency Telecommunications Service	Added prior to March 2003
GEU	Geriatric Evaluation Unit	Added prior to March 2003
GFE/GFI	Government Furnished Equipment/Information	Added prior to March 2003
GFI	Government Furnished Information	Added prior to March 2003
GGAC	Geriatrics and Gerontology Advisory Committee	Added prior to March 2003
GHATP	Graduate Healthcare Administration Training Program	August 09, 2007
GHELP	Geriatric High Risk Evaluation and Liaison Program	October 05, 2009
GI	Government Issue	July 21, 2004
GI	Gastrointestinal	August 04, 2014
GIAT	Government Installation Acceptance Test	Added prior to March 2003
GIF	Graphics Interchange Format	June 08, 2005
GIGO	garbage in garbage out	Added prior to March 2003
GILS	Government Information Locator System	Added prior to March 2003
GIP	Generic Inventory Package	Added prior to March 2003
GIPSE	Geocoded Interoperable Population Summary Exchange	June 21, 2010
GIS	Geographic Information System	July 21, 2010
GIS	Generic Interface System	Added prior to March 2003

GISRA	Government Information Security Reform Act	Added prior to March 2003
GITSS	Global Information Technology Support Services	January 25, 2007
GLIF	GuideLine Interchange Format	Added prior to March 2003
GLU	Glucose or glucose check	August 04, 2014
GM	gluteus maximus	June 16, 2015
GM	gram	April 21, 2016
GMAIL	group mail	December 14, 2016
GMDN	Global Medical Device Nomenclature	October 20, 2003
GME	Graduate Medical Education	October 22, 2015
GMI	General Mental Illness	February 16, 2011
GMR	General Medical Record	June 21, 2010
GMT	Geographic Means Test	Added prior to March 2003
GOE	General Operating Expenses	November 15, 2010
GOHR	Good Electronic Health Record	July 21, 2004
GORP	GERIATRIC ONGOING READINESS PROGRAM	April 10, 2014
GOSIP	Government Open Systems Interconnection Profile	Added prior to March 2003
GOT	Government-Off-The-Shelf	Added prior to March 2003
GOTS	Government Off-the-Shelf (applications)	April 23, 2014
GOTS	Government Off-The-Shelf	May 07, 2014
GOV	Government Owned Vehicle	March 18, 2009
GP	Government Property	May 12, 2010
GPD	Grant and Per Diem	August 14, 2007
GPDP	Grant and Per Diem Program	April 30, 2014
GPEA	Government Paperwork Elimination Act	Added prior to March 2003
GPL	General Public License	May 01, 2014
GPM	Group Practice Management	April 21, 2016
GPMRC	Global Patient Movement Requirements Center	Added prior to March 2003
GPO	Geographic Provider Organization	Added prior to March 2003
GPO	Government Printing Office	May 09, 2011
GPRA	Government Performance & Results Act	Added prior to March 2003
GPRAMA	Government Performance and Results Act Modernization Act of 2010	September 04, 2015
GPS	Global Positioning System	April 23, 2014
GRB	Government Retirement Benefits	December 15, 2016
GRC	Governance, Risk and Compliance	October 25, 2011
GRECC	Geriatric Research, Education and Clinical Center	Added prior to March 2003
GRM	Government Reference Information Model	Added prior to March 2003
GSA	General Services Administration	Added prior to March 2003
GSBCA	General Services Board of Contract Appeals	May 12, 2010
GSF	Gross Square Feet	January 23, 2007
G-SIG	Government Special Interest Group	Added prior to March 2003

GSS	General Support System	January 14, 2008
GTN	Gross to Net	July 14, 2010
GU	Genitourinary	August 04, 2014
GUID	Global Unique Device Identification	October 22, 2015
GUI	Graphic User Interface	Added prior to March 2003
GUI	Graphical User Interface	March 28, 2011
GWAC	Government Wide Area Contract	July 21, 2004
GWN	GetWellNetwork	September 23, 2014
GWN	Gateway North	October 21, 2014
GWOT	Global War On Terrorism (see Overseas Contingency Operation)	March 25, 2009
H		top
H&CBC	Home and Community Based Care	November 06, 2007
H&P	History and Physical	May 19, 2015
H&PE	History and Physical Examination	Added prior to March 2003
H/I	Homicidal Ideation	October 31, 2007
H/O	History of	December 14, 2016
HA	heache	March 23, 2015
HAC	Housekeeping Aide Closet	July 17, 2008
HAC	Health Administration Center	Added prior to March 2003
HAIG	Healthcare Analysis and Information Group	March 26, 2009
HAIG	Health Architecture Interagency Group	June 02, 2006
HAISS	Healthcare Acquired Infection and Influenza Surveillance System	March 08, 2007
HAIMS	Healthcare Artifact and Image Management Solution	October 22, 2009
HAIMS	Healthcare Artifacts and Images Management Solution	December 14, 2016
HAISS	Healthcare Associated Infection and Influenza Surveillance System	September 23, 2008
HAMP	Home Affordable Modification Program	August 11, 2015
HAND	Human Assisted Neural Devices	April 03, 2006
HAPE	Health Administration Project Enhancement	December 07, 2010
HAPI	HL7 Application Programming Interface	April 17, 2015
HARB	Health Architecture Review Board	April 30, 2014
HAS	Health Administration Services	Added prior to March 2003
HB&E	Health Benefits & Enrollment	December 14, 2016
HBC	Health Behavior Coordinator	October 25, 2010
HBHC	Hospital Based Home Care is now HBHC	Added prior to March 2003
HBIPS	Hospital Based Inpatient Psychiatric Services	July 18, 2014
HBOC	(One of the largest vendors of hospital system information software)	Added prior to March 2003
HBP	Health Benefit Plans	February 06, 2015
HBP	High Blood Pressure	October 22, 2015
HBPC	Home Based Primary Care	Added prior to March 2003
HC IDM	Healthcare Identity Management	June 04, 2009

HCA	Head's of Contracting Activity	December 15, 2016
HCBC	Home and Community Based Care	May 19, 2015
HCC	Health Care Center	September 23, 2014
HCCSL	Home and Community Care Service Line	November 01, 2005
HCEC	Health Care Ethics Consultant	April 23, 2014
HCEF	Health Care Executive Fellowship	May 24, 2011
HCERA	Health Care and Education Reconciliation Act	July 06, 2010
HCFA	Health Care Financing Administration (CMS as of 7/01)	Added prior to March 2003
HCG OR HCG	human choriaonic gonadatropin, as in pregnancy testing	August 14, 2014
HCHV	Healthcare for Homeless Veterans	Added prior to March 2003
HC-ISAC	HealthCare Information Sharing and Analysis Center	May 22, 2003
HCLDP	Health Care Leadership Development Program	May 24, 2011
HCLI	Health Care Leadership Institute	February 25, 2008
HCM	Human Capital Management	January 21, 2016
HCMI	Homeless Chronically Mentally Ill	September 23, 2014
HCP	Healthcare Claims Processing	April 17, 2014
HCPCS	Healthcare Common Procedure Coding System	July 21, 2004
HCPM	Health Care Planning Model	March 26, 2009
HCPOA	health care power of attorney	December 15, 2016
HCPS	Health Claims Processing System	May 19, 2015
HCR	HealthCare Repository	December 03, 2014
HCRV	HealthCare Reentry Veterans	October 22, 2008
HCS	Health Care System	July 06, 2009
HCS德罗	Health Care Staff Development and Retention Office	Added prior to March 2003
HCTZ	hydrochlorothiazide	August 14, 2014
HCV	Hepatitis C Virus	May 01, 2014
HD	Hemodialysis	October 22, 2008
HDD	Health Data Dictionary	July 21, 2004
HDI	Health Data and Informatics	April 15, 2010
HDL	High Density Lipoprotein	December 15, 2016
HDR	Health Data Repository	Added prior to March 2003
HDR-L	Health Data Repository-Local	February 10, 2004
HDR-N	Health Data Repository - National	July 21, 2004
HDR-P	Health Data Repository Prototype	July 21, 2004
HDS	Health Data Systems	July 21, 2004
HDS-DE	Health Data Systems-Data Exchange	April 05, 2010
HEA	Health Enterprise Architecture	July 21, 2004
HEC	Health Executive Council (VA/DoD)	Added prior to March 2003
HEC	Health Eligibility Center	Added prior to March 2003
HEC IM/IT WG	Health Executive Council Information Management/Information	May 07, 2014

	Technology Work Group	
HECMS	Health Eligibility Case Management System	September 03, 2008
HEDIS	Health Plan and Employer Data and Information Set	July 21, 2004
HERC	Health Economics Resource Center	March 20, 2008
HERL	HUMAN ENGINEERING RESEARCH LABORATORIES	January 29, 2009
HES	Health Enterprise Strategy	July 22, 2003
HEV	HealtheVet	June 19, 2007
HF	Heart Failure	May 19, 2015
HFMEA	Health Care Failure Mode and Effect Analysis	August 21, 2008
HFR	Hold for Review	October 30, 2006
HFS	Host File System	July 21, 2004
HH	Home Health	April 23, 2014
HHA	Homemaker Home Health Aide	February 25, 2008
HHAS	Headquarters Health Administration Services	Added prior to March 2003
HHC	Home Health Care	April 23, 2014
HHS	Health and Human Services	Added prior to March 2003
HHS	hand held showed	September 23, 2008
HHV	Help Hospitalized Veterans	October 20, 2011
HI2	Health Informatics Initiative	April 23, 2014
HIA	Health Information Architecture	Added prior to March 2003
HIAC	HIPAA Implementation Advisory Council	April 27, 2004
HIC	Health Information Committee	September 20, 2010
HIC	Hospital Incident Command	September 20, 2010
HICR	Hosted Intelligent Call Routing	June 27, 2011
HIDS	Host Based Intrusion Detection System	July 21, 2004
HIDU	Health Information Development Unit	October 06, 2011
HIE	Health Information Exchange	January 14, 2008
HIEA	Health Interoperability Exchange Alliance	January 21, 2016
HIG	Health Information Governance	April 23, 2014
HIIR	Health Information Integration and Resources	July 16, 2007
HILS	Heterogeneous Information Locator Service	July 21, 2004
HIM	Health Information Management	Added prior to March 2003
HIMS	Health Information Management Service	July 27, 2009
HIMSS	Healthcare Information and Management Systems Society	Added prior to March 2003
HINQ	Hospital Inquiry	April 15, 2010
HIOT	High Intensity Outpatient Treatment	July 20, 2009
HIP	Health Improvement Program	June 19, 2006
HIPAA	Health Insurance Portability and Accountability Act	Added prior to March 2003
HIPDB	Health Integrity & Protection Data Bank	October 31, 2007
HIPS	Host-based Intrusion Prevention System	June 12, 2006
HIRS	Health Information Resources Service	Added prior to March 2003

HIS	Hospital Information System	Added prior to March 2003
HIS	Health Informatics Strategy	July 22, 2003
HIS	Health Informatics Specialist	April 18, 2014
HIS	Health Information Sharing	March 31, 2010
HISA	Home Improvement Structural Alterations	June 19, 2007
HISB	Healthcare Informatics Standards Board	Added prior to March 2003
HISD	Health Information Security Division	September 08, 2008
HISEB	Health Information Systems Executive Boards	April 15, 2010
HISP	Healthcare Internet Service Provider	April 23, 2014
HISPP	Health Care Informatics Standards Planning Panel	Added prior to March 2003
HISS	Health Information Security Service	Added prior to March 2003
HIT	Health Information Technology	February 24, 2009
HIT(S)	HIPAA Implementation Team(s)	April 27, 2004
HITC	Hines Information Technology Center	April 23, 2014
HITECH	Health Information Technology for Economic and Clinical Health	February 24, 2009
HITIDE	Health Information Technology Innovation and Development	August 22, 2011
HITS	Health Information Technology Systems	June 14, 2011
HITS	Health IT Sharing	April 27, 2004
HITSC	Health Information Technology Standards Committee	May 07, 2014
HITSP	Health Information Technology Standards Panel	September 18, 2006
HIV	Human Immunodeficiency Virus	July 21, 2004
HL7	Health Level 7 (standard for electronic data exchange/messaging protocol)	Added prior to March 2003
HL7 RIM	Health Level 7 Reference Information Model	July 21, 2004
HLA	healtheliving assessment	September 23, 2014
HLD	Hyperlipidemia	April 03, 2014
HLM	Healthy Living Messages	February 02, 2011
HLO	HL7 Optimized	April 20, 2010
HMIS	History Management Information System	April 23, 2014
HMP	Health Management Platform	April 23, 2014
HMP	Health Management Platform	April 17, 2014
HMP	Heath Management Platform	May 07, 2014
HOB	Head of Bed	June 16, 2015
HOH	hard of hearing	August 04, 2014
HOLAP	Hybrid On-Line Analytical Processing	July 21, 2004
HOMES	Homeless Veterans Operations Management and Evaluation System	April 23, 2014
HOMES	Homeless Operations Management and Evaluation System	April 17, 2014
HON	HONORABLE	April 17, 2015
HOPTEL	Hospital Hotel	January 03, 2007
HOR	Home of Record	April 21, 2016

HOST	Hybrid Open Systems Technology	July 27, 2004
HOST (Federal)	Healthcare Open Systems and Trials	Added prior to March 2003
HOTN	Hypotension	February 06, 2015
HP	Hewlett Packard	July 21, 2004
HPACT	Homeless Patient Aligned Care Team	April 10, 2014
HPC	Hospice Palliative Care	May 07, 2014
HPCC	High Performance Computing and Communications	Added prior to March 2003
HPDM	High Performance Development Model	Added prior to March 2003
HPDP	Health Promotion Disease Prevention	November 18, 2010
HPID	Health Plan Identifier	April 23, 2014
HPMO	Health Program Management Office	January 05, 2006
HPOES	Health Plan and Other Entity Enumeration System	April 18, 2014
HPPD	Hours Per Patient Day	April 23, 2014
HPS	Health Provider Systems	February 10, 2004
HPSO	Health Program Support Office	October 30, 2006
HQ	Headquarters (used by VHA only)	Added prior to March 2003
HR	Human Resources	July 21, 2004
HR	hour	August 14, 2014
HR&A	Human Resources and Administration	July 21, 2004
HR&SS	Human Resources and Staffing Services	April 23, 2014
HRA	Human Resources and Administration	April 17, 2014
HRA	Health Risk Assessment	February 25, 2008
HRAC	Healthcare Resource Access Control	Added prior to March 2003
HRC	Health Resource Center	April 20, 2010
HRIS	Human Resources Information Service	November 30, 2009
HRM	Human Resources Management	Added prior to March 2003
HRMACS	Human Resources Management and Consulting Services	April 23, 2014
HRML	Human Resources Management Letter	Added prior to March 2003
HRPP	Human Research Protection Programs	March 18, 2009
HRQoL	Health Related Quality of Life	Added prior to March 2003
HRR	High Risk Report	May 03, 2007
HRSA	Health Resources Services Administration	Added prior to March 2003
HSC	Health Systems Committee	Added prior to March 2003
HSD&A	Health Systems Data and Analysis	March 26, 2009
HSD&D	Health Systems Design & Development	November 18, 2003
HSES	Health Systems Executive Service	Added prior to March 2003
HSHC	Hawaii State Healthcare Corporation	Added prior to March 2003
HSITES	Health Systems Implementation, Training, and Enterprise Support	October 06, 2003
HSM	Health Solutions Management	October 22, 2015
HSPC	Healthcare Services Platform Consortium	February 06, 2015

HSPD-12	Homeland Security Presidential Directive 12	October 14, 2010
HSR&D	Health Services Research and Development	Added prior to March 2003
HSRO	Health Systems Review Organization	Added prior to March 2003
HSSI	High Speed Serial Interface	November 10, 2003
HT/HTH	Home Telehealth	February 25, 2008
HTH	Home Telehealth	October 25, 2011
HTH	Home Telehealth	December 28, 2011
HTM	Healthcare Technology Management	October 01, 2014
HTM	Healthcare Technology Management	October 01, 2014
HTM	Healthcare Talent Management	December 29, 2009
HTML	Hypertext Markup Language	Added prior to March 2003
HTN	Hypertension	February 06, 2007
HTTP	HyperText Transfer Protocol	July 21, 2004
HTTPS	Hypertext Transfer Protocol Secure	December 14, 2009
HUBZONE	Historically Underutilized Business Zone	May 12, 2010
HUBZONE	Historically Underutilized Business Zone	May 12, 2010
HUCARES	Health Undersecretary's Capital Asset Realignment for Enhanced Services	April 11, 2007
HUD/VASH	Department of Housing and Urban Development/Department of Veterans Affairs Supported Housing	August 17, 2010
HUD/VASH	HUD/VA SUPPORTED HOUSING	December 14, 2016
HUD-VASH	Housing and Urban Development-Veterans Affairs Supported Housing	August 12, 2009
HUG	Human User Group	Added prior to March 2003
HUGN	Human Gene Nomenclature	May 07, 2004
HVA	Hazards Vulnerability Analysis	April 17, 2014
HVAC	House Veterans Affairs Committee	Added prior to March 2003
HVCC	Home Valuation Code of Conduct	November 08, 2010
HVCES	Homeless Veteran Community Employment Services	December 08, 2016
HVLT	Hopkins Verbal Learning Test	May 01, 2014
HVRP	Homeless Veterans' Reintegration Program	April 21, 2010
HVSEP	Homeless Veterans Supported Employment programs	April 15, 2014
HVT	HealtheVet	July 21, 2004
HWBP	Heparin Weight Based Protocol	April 23, 2014
HWSC	HealtheVet Web Service Client	April 23, 2007
HWY	hallway	September 04, 2015
HX OR HX	History or History of	August 04, 2014
I		top
I&D OR ID	Incision and drainage	August 14, 2014
I&I Laboratory	Integration and Interoperability Laboratory	Added prior to March 2003
I&O OR IO	In take and out put	August 14, 2014

I&R	Information and Referral	Added prior to March 2003
IA	Integration Agreement	July 21, 2004
IA	Identification, Authentication	December 15, 2009
IAA	Interagency Agreement	November 08, 2010
IAA	Identification, Authentication, and Authorization	July 21, 2004
IAB	Initial Assessment and Briefing	April 11, 2007
IACUC	Institutional Animal Care and Use Program	March 18, 2009
IADL	Instrumental Activities of Daily Living	March 17, 2009
IADS	Initial Architecture and Interface Design Strategy	July 21, 2004
IADT	Initial Active Duty for Training	December 08, 2009
IAE	Interim Address Enhancements	October 01, 2003
IAM	Identity and Access Management	July 27, 2009
IAP	Information Access and Privacy	April 15, 2010
IAS	Internal Audit Service	Added prior to March 2003
IASR	integrated Architecture Summary Report	May 07, 2014
IATO	Interim Authority to Operate	Added prior to March 2003
IAW	In Accordance With	November 21, 2007
IB	Insurance Buffer	February 18, 2010
IB	Incident Briefing	April 03, 2014
IB	Integrated Billing	Added prior to March 2003
IBBA	Intranet BDN/BIRLS Access	Added prior to March 2003
IBM	International Business Machines	July 21, 2004
IBR	Integrated Baseline Review	April 27, 2009
IBRD	integrated Business Requirements Document	May 07, 2014
IBRM	integrated Business Reference Model	May 07, 2014
ICAM	Identity, Credential, and Access Management	December 03, 2014
ICARE	Integrity, Compassion, Advocacy, Respect & Excellence	September 23, 2014
ICB	Insurance Capture Buffer	May 07, 2009
ICB	Insurance Card Buffer	February 18, 2010
ICB	Information Collection Budget	Added prior to March 2003
ICCD	International Change Control Board	July 21, 2004
ICD	Interface Control Document	July 21, 2004
ICD	ISO Consultation Division	April 23, 2014
ICD	International Classification of Diseases	Added prior to March 2003
ICD	Insurance Claims Division	Added prior to March 2003
ICD	Informed Consent Document	December 15, 2016
ICD-10 CM	International Classification of Diseases, 10th Edition, Clinical Modifications	April 15, 2010
ICD-9, ICD-10	International Classification of Diseases, Ninth or Tenth Revision	February 06, 2015
ICD-9, ICD-10	International Classification of Diseases, Ninth or Tenth Revision	February 06, 2015
ICD-9-CM	International Classification of Diseases--9th edition--Clinical	Added prior to March 2003

	Modification	
ICDB	Interoperative Clinical Database	December 15, 2003
ICDR	Interactive Clinical Data Repository	July 21, 2004
ICE	In Case Of Emergency	July 10, 2006
ICFM	Integrated Collections Forecasting Model	May 07, 2014
ICFM	Integrated Collections Forecasting Model	April 30, 2014
ICFS	Infrastructure, Common Services, and Foundations	August 25, 2008
ICIB	Interagency Clinical Informatics Board	September 09, 2008
ICIDH	International Classification of Impairments, Disabilities & Handicaps	Added prior to March 2003
ICIDH-2	International Classification of Impairments, Activities & Participation	Added prior to March 2003
ICL	Isolated Customer LAN	January 14, 2008
ICN	Integration Control Number	May 17, 2004
ICOM	Inputs, controls, outputs and mechanisms	December 01, 2009
ICOO	Internal Controls over Operations	April 21, 2016
ICP	Intermittent Catheterization Protocol	April 15, 2010
ICP	Infection Control Professional	October 14, 2008
ICPT	Integrated Clinical Program Review Team	January 21, 2016
ICR	Integration Control Registration	November 16, 2011
ICR	Immunology Case Registry	Added prior to March 2003
ICRA	Infection Control Risk Assessment	August 31, 2011
ICS	Integrated Campus Support	June 27, 2011
ICS	Internal Controls Service	February 01, 2010
ICS	Incident Command System	April 17, 2014
ICTAP	Interagency Career Transition Assistance Program	November 04, 2009
ICU	Intensive Care Unit	July 21, 2004
ICWG	Internal Control Work Group	May 11, 2006
ID	Identification	April 18, 2014
IDC	Interim Data Center	May 12, 2010
IDCU	Integrated Data Communications Utility	Added prior to March 2003
IDD	Interface Design Document	November 18, 2003
IDE	Integrated Development Environment	May 16, 2005
IDE	Integrated Drive Electronics	February 02, 2006
IDES	Integrated Disability Evaluation System	December 08, 2010
IDIQ	Indefinite Delivery/Indefinite Quantity	Added prior to March 2003
IDL	Interface Definition Language	Added prior to March 2003
IDL	Iterative Development Lifecycle	October 01, 2003
IDM	Independent Domiciliary (independently operated and non managed by MC)	Added prior to March 2003
IDM	Identity Management	December 10, 2014
IDM	Identity Management	December 10, 2014

IDMC	Informatics & Data Management Committee	Added prior to March 2003
IDMS	Identity Management System	October 06, 2011
IDP	Individual Development Plan	October 20, 2006
IDPO	Infectious Disease Program Office	November 16, 2011
IDRP	Innovation and Development Request Portal	April 23, 2014
IDS	Intrusion Detection Systems	Added prior to March 2003
IDT	Interdisciplinary Team	April 23, 2014
IDTP	Intensive Day Treatment Program	October 30, 2014
IE	Interface Engine	Added prior to March 2003
IE POC	IntegratedEthics Point of Contact	April 23, 2014
IEAB	IntegratedEthics Advisory Board	April 23, 2014
IEC	IntegratedEthics Council	April 23, 2014
IED	Improvise Explosive Device	March 09, 2007
IEDS	Investment & Enterprise Development Service	April 30, 2014
IEEE	Institute of Electrical and Electronic Engineering	Added prior to March 2003
IEEE1073	Electrical and Electronics Engineers 1073	March 24, 2003
iEHR	integrated Electronic Health Record	May 03, 2011
IEN	Internal Entry Number	July 21, 2004
IEPO	IntegratedEthics Program Officer	April 23, 2014
IER	Information Exchange Requirements	March 02, 2009
IESS	IntegratedEthics Staff Survey	April 23, 2014
IETF	Internet Engineering Task Force	July 21, 2004
IFAS	Integrated Financial Accounting System	October 31, 2007
IFB	Invitation for Bids	May 13, 2010
IFC	Interfacility Consult	November 04, 2009
IFCAP	Integrated Funds Control, Accounting, and Procurement	April 15, 2010
IFM	Ineligible due to Forms Missing	November 04, 2009
IFMB	Integrated Financial Management Board	July 26, 2010
IFMC	Iowa Foundation for Medical Care	May 07, 2004
IFMS	Integrated Financial Management Standard	Added prior to March 2003
IFMT	Integrated Flow Management Tool	December 15, 2016
IFN	Item(s) For Negotiation	April 15, 2014
IFN	Item for Negotiation	May 07, 2014
IFR	Interim Final Rule	February 18, 2010
IFR	Institution File Redesign	Added prior to March 2003
IG	Inspector General	Added prior to March 2003
IGCE	Independent Government Cost Estimate	September 09, 2008
IGUI	integrated Graphical User Interface	May 07, 2014
IH	Industrial Hygienist	November 16, 2009
IHDR	Interactive Health Data Repository	July 21, 2004

IHE	Integrating the Healthcare Enterprise	December 14, 2005
IHI	Institute for Healthcare Improvement	November 15, 2010
IHOP	Integrated Health Operating Plan	April 17, 2014
IHP	Internal High Priority	Added prior to March 2003
IHS	Indian Health Service	Added prior to March 2003
IHS	Integrated Hospital System	Added prior to March 2003
IHSS	In-Home Supportive Services	April 10, 2014
IHTSDO	International Health Terminology Standards Development Organization	June 09, 2008
II&V	Insurance Identification and Verification	October 01, 2003
IIA	Institute of Internal Auditors	February 18, 2010
IICU	Intermediate Intensive Care Unit	August 14, 2014
IIHI	Individually Identifiable Health Information	Added prior to March 2003
IIMR	integrated Information Model Report	May 07, 2014
IIOP	Internet Inter-ORB Protocol	Added prior to March 2003
IIP	Informatics Innovation Project	Added prior to March 2003
IIP	VA Innovation Intern Program	May 01, 2014
IIP	Information Interoperability Plan	June 09, 2008
IIRC	If I Recall Correctly	December 14, 2016
IIS	Internet Information Servers	Added prior to March 2003
IIS	Information Infrastructure Systems	July 21, 2004
IITMB	Integrated Information Technology Management Board	March 31, 2010
IIV	Insurance Identification and Verification	October 25, 2011
IKE	Internet Key Exchange	March 23, 2007
IL	Information Letter	July 06, 2010
ILER	Individual Longitudinal Exposure Record	November 18, 2015
ILL	Interlibrary Loan	Added prior to March 2003
ILO	In lieu of	November 05, 2008
ILSM	Interim Life Safety Measures	August 31, 2011
ILT	Instructor Led Training	February 06, 2015
IM	intramuscular	August 04, 2014
IM	Information Management	Added prior to March 2003
IM/DQ	Identity Management/Data Quality	February 22, 2005
IM/IT	Information Management/Information Technology	Added prior to March 2003
IMACD	Install, Move, Add, Create, Delete	December 15, 2016
IMC	Intermediate Care	Added prior to March 2003
IMDQ	Identity Management Data Quality	July 12, 2006
IMHO	In my humble opinion	October 21, 2014
IMM	Integration Medication Manager	May 05, 2010
IMO	Inpatient Medications for Outpatients	April 19, 2005
IMP	Integrated Master Plan	September 14, 2009

IMPAC	International Merchant Purchase Authorization Card	Added prior to March 2003
IMPACT	Intensive Management Patient Aligned Care Teams	April 10, 2014
IMR	Inpatient Medication Requests	April 27, 2009
IMR	Individual Medical Readiness	April 11, 2007
IMRB	Internet Management Review Board	Added prior to March 2003
IMS	Interim Messaging Solution	May 19, 2004
IMS	Integrated Master Schedule	September 14, 2009
IMS	Instant Messaging Server	May 01, 2014
IMSR	Information Model Summary Report	December 03, 2014
IMT&R	Information Management, Technology and Reengineering	Added prior to March 2003
IND	Investigational New Drug	May 03, 2011
INH	Inhale or Inhalation	August 14, 2014
INS	Immigration and Naturalization Service	Added prior to March 2003
INSP	Inspiratory, as in lung sound assessment	August 14, 2014
INTMED	Internal Medicine	August 12, 2010
IOC	Initial Operating Capabilities	January 19, 2010
IOC	Integrated Operations Center	June 27, 2011
IOC	Independent Outpatient Clinic	Added prior to March 2003
IOC	Independent Outpatient Clinic	Added prior to March 2003
IOC	Integrated Operations Center	December 14, 2016
IOM	Institute of Medicine	July 21, 2004
IOM	Integrated Operating Model	January 10, 2011
IOP	Intensive Outpatient Program	April 03, 2014
IORBA	Inter-Organizational Role-Based Access	Added prior to March 2003
IORM	Integrated Organizational Role Models	May 07, 2014
IOT	In order to	September 23, 2014
IOWG	Interoperability Work Group	October 31, 2006
IP	Intelligent Properties	March 02, 2009
IP	Internet Protocol	Added prior to March 2003
IPA	In Depth Pain Assessment	November 27, 2007
IPA	In-Person Authentication	December 21, 2006
IPA	Intergovernmental Personnel Act	April 29, 2010
IPAC	Intra-governmental Payment and Collection	March 20, 2008
IPC	Intake Processing Center	June 06, 2014
IPD	Intermediate Product Department	April 23, 2014
IPDB	Integrated Patient Database	Added prior to March 2003
IPEC	Inpatient Evaluation Centers	April 17, 2007
IPERA	Improper Payments Elimination and Recovery Act	December 07, 2010
IPERIA	Improper Payments Elimination & Recovery Improvement Act	April 23, 2014
IPF	Integrated Patient Funds	April 24, 2003

IPIA	Improper Payments Information Act of 2002	February 11, 2009
IPL	Initial Program Load	May 07, 2014
IPLRD	integrated Project Level Requirements Document	May 01, 2014
IPM	Inpatient Medications	December 11, 2007
IPO	Interagency Program Office	April 29, 2008
IPPS	Invoice Payment and Processing System	February 06, 2015
IPR	In-Process Review (or In-Progress/DoD acronym)	Added prior to March 2003
IPRM	Information Protection and Risk Management	December 21, 2010
IPRO	Improper Payments Reporting and Oversight	April 21, 2016
IPS	Informatics Patient Safety	December 15, 2016
IPS	Intrusion Protection System	March 23, 2015
IPS	Innovation & Procurement Service	January 25, 2005
IPSAW	Information Security and Privacy Awareness Week	April 19, 2016
IPSEC	Internet Protocol Security	July 21, 2004
IPT	Integrated Project Team	Added prior to March 2003
IPT	interpersonal therapy	April 23, 2014
IPT	Integrated Product Team	March 31, 2010
IPT	Integrated Process Teams	February 18, 2010
IPU	inpatient psychiatric unit	April 10, 2014
IPV	Intimate Partner Violence	April 21, 2016
IPV4	Internet Protocol Version 4	June 21, 2010
IPV6	Internet Protocol Version 6	June 21, 2010
IQ	Intranet Quorum	December 02, 2009
IR	Interventional Radiology	August 14, 2014
IR	Insurance Review	April 17, 2014
IR	Incident Report	July 21, 2004
IR5	Iterative Release 5	July 10, 2006
IRA	Initial Requirements Analysis	April 16, 2003
IRAC	Information Resources Advisory Council	Added prior to March 2003
IRATIP	Intranet Remote Access Transport Improvement Project	July 21, 2004
IRB	Institutional Review Board	May 05, 2010
IRC	Internet Relay Chat	July 21, 2004
IRC	Internal Readiness Committee	December 15, 2016
IRC Lab	Integration and Research Center Laboratory	Added prior to March 2003
IRCN	Interagency Reports Control Number	Added prior to March 2003
IRCT	Incident Resolution Core Team	April 30, 2007
IRDC	Informatics Research Design Center	February 14, 2012
IRF-PAI	Inpatient Rehabilitation Facility-Patient Assessment Instrument	March 02, 2009
IRGB	VA Incident Response Governance Board	November 05, 2009
IRIS	Inquiry Routing & Information System	Added prior to March 2003
IRM	Information Resources Management	Added prior to March 2003

IRM	Incident Response Message	July 30, 2015
IRMCO	Interagency Resources Management Conference	October 01, 2003
IRMFO	Information Resources Management Field Office	Added prior to March 2003
IRMS	Information Resource Management Systems	January 11, 2005
IRP	Incident Response Plan	April 17, 2014
IRP	Incident Response Plan	April 23, 2014
IRR	Individual Ready Reserve	December 14, 2009
IRSD	IAM Integration Requirements Specification Document	April 23, 2014
IRT	Incomplete Records Tracking	Added prior to March 2003
IRT	In Reference to	October 29, 2015
IRWG	Investment Review Working Group	June 19, 2006
ISA	Industry Standard Architecture	February 02, 2006
ISA	Information Security Agreement	September 19, 2006
ISA	Interconnection Security Agreement	April 10, 2014
ISBN	International Standard Book Number	July 21, 2004
ISBT	International System of Bar Code Technology	Added prior to March 2003
ISC	Information Systems Center	Added prior to March 2003
ISC	intermittent self catheterizaiton	April 23, 2014
ISC	intermittent self catheterizaiton	April 23, 2014
ISC	Integrated Steering Committee	June 11, 2014
ISCH	Insulin Dependent Diabetes Mellitus	April 21, 2016
ISCP	Information Systems Contingency Plan	April 23, 2014
ISCPA	Information Systems Contingency Plan Assessment	June 27, 2011
ISCSI	Internet Small Computer System Interface	February 02, 2006
ISD	Instructional System Design	April 05, 2010
ISD	Integrated Systems Deployment	December 15, 2016
ISDN	Integrated Services Digital Network	Added prior to March 2003
ISI	Information Sharing Initiative	June 14, 2011
ISIL	Interagency Software Integration Lab	Added prior to March 2003
ISITE	Integrated Self-Instructive Test Equipment	June 25, 2014
ISMS	Integrated Supply Management System	Added prior to March 2003
ISO	International Standards Organization	Added prior to March 2003
ISO	Information Security Officer	July 21, 2004
ISO-TC	International Organization for Standardization Technical Committee	Added prior to March 2003
ISP	Internet Service Provider	July 21, 2004
ISP	Individual Service Plan	October 31, 2007
ISPAW	Information Security and Privacy Awareness Week	May 19, 2015
ISSL	Information Systems Service Line	February 25, 2008
ISSUES	Identify, Study, Select Strategy, Undertake Plan, Evaluate & Adjust, Sustain & Spread	April 23, 2014

IT	Information Technology	Added prior to March 2003
IT MYP	Information Technology Multi-Year Programming	June 11, 2014
IT&IMS	Information Technology & Management Sharing (VHA/DoD)	Added prior to March 2003
ITA	Information Technology Architecture (VHA)	Added prior to March 2003
ITAAC	IT Acquisition Advisory Council	April 27, 2010
ITAAG	Information Technology Asset Allocation Group	April 23, 2014
ITAC	Information Technology Advisory Committee	Added prior to March 2003
ITAM	IT Asset Management	June 27, 2011
ITAM	Information Technology Account Manager	May 28, 2016
ITARG	Integration and Technology Application Requirements Group	Added prior to March 2003
ITARP	IT Activity Resource Proposal	July 27, 2009
ITARS	IT Acquisition Request System	July 21, 2009
ITB	Information Technology Board	July 21, 2004
ITBAT	IT Budget Analysis Team	March 01, 2010
ITC	Information Technology Center	July 29, 2009
ITC	Information Technology Conference	Added prior to March 2003
ITDB	Interim Theater Database	October 18, 2005
ITE	Independent Test and Evaluation	April 30, 2014
ITE	In the Ear	April 23, 2014
ITEAM	Information Technology Enterprise Architecture Management	August 09, 2004
ITF	Intent to File	October 22, 2015
ITIL	Information Technology Infrastructure Library	March 27, 2007
I-TIPS	Information Technology Investment Portfolio System	Added prior to March 2003
ITLB	Information Technology Leadership Board	April 15, 2008
ITLO	InformationTechnology Logistics Office	January 25, 2008
ITMP	Information Technology Management Program	Added prior to March 2003
ITMRA	Information Technology Management Reform Act	Added prior to March 2003
ITN	Incident Ticket Number	April 21, 2016
ITOC	Information Technology and Oversight Compliance	October 28, 2009
ITOC	Information Technology Oversight & Compliance	October 31, 2011
ITOPS	IT Operations and Services	December 28, 2016
ITP	Intent to Proceed	January 11, 2006
ITPROG	Information Technology Program Manager	April 10, 2014
ITPT	Information Technology Process Team	September 27, 2010
ITRM	IT Resource Management	September 10, 2008
ITS	Information Technology Specialist	January 29, 2009
ITS	Information Technology Specialist	January 29, 2009
ITS	Implementation and Training Services	July 21, 2004
ITSCAP	Information Technology Security Certification and Accreditation Program	July 21, 2004
ITSL	Information Technology Service Line	November 05, 2008

ITSM	IT Service Management	April 30, 2014
ITSR	Information Technology Service Request	April 11, 2007
ITU	International Telecommunications Union	July 21, 2004
ITWD	IT Workforce Development	March 21, 2014
IU	Individual Unemployability	December 15, 2016
IV	Insurance Verification	April 15, 2014
IV	Intravenous	December 11, 2007
IV&V	Independent Verification and Validation	Added prior to March 2003
IVA	Integrated Vista Adapter	August 11, 2015
IVAP	Income for VA Purposes	April 03, 2015
IVM	Income Verification Match	Added prior to March 2003
IVMC	Income Verification Match Center	Added prior to March 2003
IVMH	Improve Veterans Mental Health	July 26, 2010
IVN	Interactive visual navigator	April 23, 2014
IVP	Intra Venous Push	March 20, 2008
IVP	Insurance Verification Processor	January 21, 2016
IVPB	Intra Venous Piggy Back	March 20, 2008
IVSP	Intravenous Slow Push	December 03, 2014
IVV	Independent Verification and Validation (IV&V)	March 27, 2007
J		top
J2CA	Java 2 Connector Architecture	July 21, 2004
J2EE	Java 2 Enterprise Edition	July 21, 2004
J2SE	Java 2 Standard Edition	July 21, 2004
JAAS	Java Authentication and Authorization Service	August 16, 2005
JACC	Joint Ambulatory Care Center	October 03, 2011
JAD	Judicial Applications Design	July 21, 2004
JAD	Joint Application Development	Added prior to March 2003
JALFHCC	James A. Lovell Federal Health Care Center	July 29, 2009
JAR	Java ARchive	January 11, 2006
JAWS	Job Access With Speech	April 23, 2014
JCAHO	Joint Commission on Accreditation of Healthcare Organizations (See TJC)	May 24, 2010
JCIB	Joint Clinical Information Board (ICIB replaces JCIB)	September 09, 2008
JCIDS	Joint Capabilities Integration and Development Systems	May 07, 2014
JDBC	Java Database Connectivity	June 08, 2005
JEC	Joint Executive Council (VA/DoD)	Added prior to March 2003
JEHRI	Joint Electronic Health Records Interoperability (Program)	February 28, 2007
JEMR	Joint Electronic Medical Record	May 20, 2004
JET	Joint Exploratory Team	January 21, 2016
JFSG	Joint Health Care Facility Operations Steering Group	October 25, 2006

JHITA	Joint Healthcare Information Technology Alliance	Added prior to March 2003
JIF	Joint Incentive Fund	July 11, 2007
JIT	Just-in-Time	April 23, 2014
JITC	Joint Integration and Test Center	May 07, 2014
JITC	Joint Interoperability Test Command	April 23, 2014
JIV	Joint Interoperability Ventures	April 15, 2010
JLC	Joint Leadership Council	July 30, 2015
JLV	Joint Legacy Viewer	April 23, 2014
JMS	Java Messaging Service	June 08, 2005
JNDI	Java Naming Directory Interface	October 01, 2003
JOTFOC	Justification for Other Than Full and Open Competition	August 12, 2009
JP	Jackson-Pratt (drain)	April 21, 2016
JPEG	Joint Pictures Expert Group	June 08, 2005
JPO	Joint Project Office	Added prior to March 2003
JPTA	Joint Patient Tracking Application (DoD application)	September 11, 2006
JRD	Journal of Rehabilitation Research and Development	August 30, 2011
JSI	Job Satisfaction Inventory	March 18, 2009
JSON	JavaScript Object Notation	April 23, 2014
JSP	Java Server Pages	June 08, 2005
JSP	Joint Strategic Plan	June 19, 2007
JSRRC	Joint Services Records Research Center	February 01, 2010
JTCC	Joint Transportation Corporate Information Management Center	Added prior to March 2003
JTPO	Joint Technology Program Office (VA/DoD)	August 22, 2007
JV	Journal Vouchers	October 04, 2010
JVBOC	Joint Venture Business Operations Committee	Added prior to March 2003
JVM	Java Virtual Machine	July 21, 2004
JVS	Joint Venture Sites	Added prior to March 2003
K		top
KAAJEE	Kernel Authentication & Authorization for J2EE	March 14, 2005
KB	Knowledge Base	April 21, 2010
KBI	Knowledge Based Information	April 15, 2010
KEF	Key Enabling Function	July 21, 2004
KHA	Killed in Hostile Action	April 10, 2014
KIDS	Kernel Installation & Distribution System	Added prior to March 2003
KP	Kaiser Permanente	June 21, 2010
KPI	Key Performance Index	February 06, 2015
KPI	Key Performance Indicator	February 06, 2015
KSA	Knowledge, Skills, Abilities	Added prior to March 2003
KSAO	Knowledge, Skills, Abilities, and Other	Added prior to March 2003
KWAPI	Kernel Windows Application Program Interface	Added prior to March 2003

KWIC	Key Word In Context (KWIC)	June 16, 2015
L		top
L	Left	August 14, 2014
L&P	Load & Performance	March 23, 2015
L/NC	liters per nasal cannula	November 13, 2015
L32	Lightweight C32 Implementation	December 22, 2009
LA	Loan Administration	October 04, 2010
LAB	Laboratory or Laboratory Value	August 14, 2014
LAD	Left Anterior Descending Artery	January 31, 2006
LAN	Local Area Network	Added prior to March 2003
LAPP	Lender Appraisal Processing Program	July 14, 2010
LAQ	Long Arc Quad	September 23, 2008
LAS	Legal Administrative Specialist	July 30, 2015
LBGT	lesbian, bisexual, gay, transgender	April 23, 2014
LBP	low back pain	October 22, 2015
LBX	Lockbox First Party	December 16, 2011
LCC	Life Cycle Costs	May 13, 2010
LCFR	Lifecycle Funding Requirement	November 16, 2011
LCP	Letter Change Proposal	May 13, 2010
LCSW	Licensed Clinical Social Worker	July 06, 2010
LCTA	LUNGS CLEAR TO AUSCULTATION	December 14, 2016
LDAP	Lightweight Directory Access Protocol	Added prior to March 2003
LDI	Leadership Development Institute	September 12, 2007
LDIF	Lightweight Directory Interchange Format	June 14, 2011
LDL	Low Density Lipoprotein	May 24, 2010
LDQT	Logistics Data Query Tool	August 14, 2008
LDSI	Lab Data Sharing and Interoperability	July 10, 2006
LE	Lower extremity	September 23, 2014
LE	Local Environment	July 21, 2004
LEA	Law Enforcement Agency	Added prior to March 2003
LEAD	Leadership Effectiveness and Development	June 04, 2004
LEAF	Logistics, Engineering, Acquisition, and Finance	June 02, 2010
LEDI	Laboratory Electronic Data Interchange	Added prior to March 2003
LEIE	List of Excluded Individuals and Entities	June 08, 2012
LEIPR	Longitudinal Enterprise Integrated Patient Record	April 23, 2014
LES	Leave and Earnings Statement	May 10, 2010
LF	Life Flight	August 14, 2014
LFT	liver function tests	August 04, 2014
LFT	Limited Field Test	January 21, 2016
LG	Loan Guarantee	Added prior to March 2003

LGY	Loan Guaranty Service	June 27, 2011
LH	Luteinizing Hormone	April 21, 2016
LIE	Legal Instruments Examiner	March 05, 2009
LIMS	Laboratory Information Management System	February 25, 2008
LIP	Licensed Independent Practitioner	March 20, 2008
LJWG	Laboratory Joint Working Group	Added prior to March 2003
LLQ	Left lower quad of abdomen	August 04, 2014
LLQ	Left lower quad of abdomen	August 04, 2014
LM	Left Message	October 21, 2014
LMA	laryngeal mask airway	August 04, 2014
LMFT	Licensed Marriage and Family Therapist	December 15, 2016
LMIP	Laboratory Management Index Program	September 12, 2007
LMN	Letter of Medical Necessity	December 15, 2016
LMOM	Left Message on Machine	October 21, 2014
LMS	Learning Management System	February 10, 2004
LMVM	Left Message Voice Mail	December 03, 2014
LN	liquid nitrogen	December 14, 2016
LNO	Library Network Office	April 05, 2010
LO	LOt	June 25, 2014
LOA	Line Of Action	June 28, 2007
LOB	Line of Business	July 21, 2004
LOC	Loss of Consciousness	April 23, 2014
LOD	Line of Duty	December 14, 2016
LOE	Level Of Effort	June 04, 2009
LOINC	Logical Observation Identifiers, Names, and Codes	Added prior to March 2003
LP	Loan Production	October 04, 2010
LP	Locality Pay	October 04, 2010
LPC	Licensed Professional Counselor	April 07, 2011
LPES	Legacy Product Enhancement Service	November 10, 2009
LPN	Licensed Practical Nurse	January 04, 2012
LQS	Lexicon Query Service	Added prior to March 2003
LR	Lactate Ringers	August 14, 2014
LRAC	Local Reasonable Accommodations Coordinator	April 18, 2014
LRAC	Local Reasonable Accommodation Coordinator	April 17, 2014
LRAC	Local Reasonable Accommodation Coordinator	April 23, 2014
LRC	Local Recovery Coordinator	August 06, 2007
LRC	Learning Resources Center	Added prior to March 2003
LRRP	Long-range Reconnaissance Patrol	May 19, 2015
LRRPS	Long-range Reconnaissance Patrols	May 19, 2015
LSC	Logistic Support Chief	August 14, 2014
LSRI	Laboratory System Re-engineering Initiative	February 25, 2008

LSRP	Laboratory System Re-Engineering Project	May 17, 2007
LST	Life-Sustaining Treatment	December 14, 2016
LSTAT	Life Support for Trauma and Transport	Added prior to March 2003
LTC	Long Term Care	Added prior to March 2003
LTCI	Long Term Care Institute	November 23, 2011
LTP	Legacy Transition Plan	May 07, 2014
LTR SNT	LETTER SENT	August 25, 2011
LTS	Long Term Solution	December 16, 2011
LUE	Left Upper Extremity	December 15, 2016
LUM	Low-Unit-of-Measure Distribution	April 23, 2014
LUN	Logical Unit Number	June 11, 2014
LUQ	left upper quadrant of abdomen	August 04, 2014
LUTS	Lower urinary tract symptoms	June 08, 2012
LV	Low Vision	December 14, 2010
LVER	Local Veteran Employee Representative	April 10, 2014
LWBS	Left Without Being Seen	August 19, 2011
LWOP	Leave Without Pay	September 23, 2014
M		top
M	MUMPS (Massachusetts General Utility Multi-Programming System)	July 21, 2004
M&IS	Messaging and Interface Services	July 21, 2004
M&M	Morbidity and Mortality	December 17, 2007
M&ROC	Medical and Regional Office Center	Added prior to March 2003
M/L	Message Left	April 17, 2015
M21	M21 Compensation and Pension Manual	December 14, 2016
MA	Medical Assistant	December 15, 2016
MA	Managment Analysis	July 21, 2004
MA	Management Analyst	April 23, 2014
MA	Major Application	January 06, 2009
MAA	Medical Administration Assistant	May 01, 2014
MAAG	MHS Application Access Gateway	April 18, 2014
MABPR	Management Analysis/Business Process Reengineering Program	May 24, 2011
MAC	Medicare and Medicaid Analysis Center	March 26, 2009
MAC	Media Access Control	June 08, 2005
MAC	Mandatory Access Control	July 21, 2004
MAC	Messaging Authentication Code	July 21, 2004
MAC	Management Advisory Consortium	Added prior to March 2003
MACE	Military Acute Concussions Evaluation	June 14, 2011
MACPAC	Mid-Atlantic Consolidated Patient Account Center	February 04, 2010
MADM	Milestone Acquisition Decision Memorandum	June 25, 2014

MADSS	Managment and Decision Support System	July 21, 2004
MAE	Moving All Extremities	May 14, 2007
MAE	Mobile Application Environment	October 21, 2014
MAF	MUMPS AudioFax	Added prior to March 2003
MALE	Memorial Affairs Letters Enhancements	August 19, 2011
MAMC	Madigan Army Medical Center	September 12, 2007
MAMOE	Medical Administration and Miscellaneous Operating Expenses	Added prior to March 2003
MAN	Metropolitan Area Network	July 21, 2004
MAPD	Modern Award Processing Development	May 26, 2011
MAP-D	Modern Award Processing Development	June 09, 2010
MAPR	Mission Assurance Planning Repository	January 21, 2016
MAPR	Maximum Annual Pension rate	March 23, 2015
MAPUE	Memorial Affairs Performance and Usability Enhancements	June 14, 2011
MAR	Memorial Affairs Re-design	June 14, 2011
MAR	Medical Administration Record	Added prior to March 2003
MARC	Multi-Technology Automated Reader Card	Added prior to March 2003
MARG	Management Applications Requirements Group	Added prior to March 2003
MAS	Medical Administration Service	Added prior to March 2003
MASS	Medical Appointment Scheduling System	April 21, 2016
MATMO	Medical Advanced Technology Management Office	Added prior to March 2003
MAVERIC	Massachusetts Veterans Epidemiology Research and Information Center	May 17, 2007
MBI	Maslach Burnout Inventory	March 18, 2009
MBI	Moderate Background Investigation	June 14, 2011
MBI	Moderate Background Investigation	June 14, 2011
MBM	Meds by Mail	November 23, 2011
MBMS	Memorials Business Management System	February 06, 2015
MBS	Modified Barium Swallow	September 23, 2014
MBSR	Mindfulness-Based Stress Reduction	August 17, 2010
MC	Medical Center	Added prior to March 2003
MCAO	Managerial Cost Accounting Office	April 23, 2014
MCAP	Managerial Cost Accounting Program	October 21, 2014
MCCF	Medical Care Collections Fund	August 12, 2009
MCCF	Medical Care Cost Fund	April 17, 2008
MCCR	Medical Care Cost Recovery	Added prior to March 2003
MCG	Medical Care Group	January 11, 2010
MCIS	MHS CyberInfrastructure Services	May 01, 2014
MCM	Medical Center Memorandum	March 23, 2005
MCO	Managed Care Organizations	Added prior to March 2003
MCS	Managed Care System	Added prior to March 2003
MCUS	Multipoint Control Units	July 30, 2015

MDA	Milestone Decision Authority	May 07, 2014
MDC	M Development Committee	Added prior to March 2003
MDCR	Modular Data Collection & Recording	June 23, 2008
MDD	Major Depressive Disorder	May 19, 2015
MDDS	Medical Device Data Systems	March 02, 2009
MDE	M Data Extraction	Added prior to March 2003
MDHT	Model-Driven Health Tools	October 25, 2010
MDIA	Medical Device Isolation Architecture	April 18, 2014
MDISS	Medical Device Innovation, Safety and Security Consortium	June 27, 2011
MDO	Medical Domain Objects	November 22, 2004
MDR	Meta Data Registry	June 16, 2003
MDRC	Management Decision and Research Center	Added prior to March 2003
MDRO	Multiple Drug Resistant Organism(s)	April 04, 2011
MDS-HC	Minimum Data Set Home Care	Added prior to March 2003
MDWS	Medical Domain Web Services	March 31, 2009
ME/NILCO	Code ME/NILCO	February 06, 2015
MEAV	Medical Equipment Asset Value	September 23, 2014
MEB	Medical Executive Board	April 17, 2015
MED	Mobile Electronic Documentation	February 05, 2009
MED	Medical Electronic Documentation	February 25, 2008
MED	Medication or Medicine Team	August 14, 2014
MED	Medication or Medicine	August 14, 2014
MEDI PRO	Medical District Initiated Peer Review Organization	Added prior to March 2003
MEDNET	Medical Network	Added prior to March 2003
MEFS	Management, Enrollment and Financial Systems	April 23, 2007
MEG	Mid Epigastric quadrant of Abdomen	August 04, 2014
MEO	Most Efficient Organization	Added prior to March 2003
MEP	Mechanical, Electrical & Plumbing	March 23, 2009
MERRT	Medical Emergency Radiological Response Team	December 10, 2014
MET	Motivational Enhancement Therapy	April 23, 2014
MF	Medical Facilities	June 14, 2011
MFD	Multi-Functional Device	September 16, 2011
MFH	Medical Foster Home	March 17, 2009
MFS	Management and Financial Systems	March 20, 2008
MFS	Management and Financial Systems	April 15, 2010
MFS	Master File Server	January 25, 2005
MGIB	Montgomery GI Bill	Added prior to March 2003
MGT	management	January 21, 2016
MH	mental health	August 14, 2014
MHA	Mental Health Assistant	February 25, 2008

MHAC	Mental Health Assessment Clinic	September 23, 2014
MHACC	MENTAL HEALTH AMBULATORY CARE CLINIC	April 17, 2015
MHBSS	Mental Health and Behavioral Sciences Service	January 06, 2009
MHC	Mental Health Clinic	January 03, 2007
MHEC	Mental Health Evaluation Clinic	April 27, 2010
MHI	Mental Health Issue(s)	October 29, 2015
MHICM	Mental Health Intensive Case Mangement	April 23, 2014
MHICM	Mental Health Intensive Care Management	Added prior to March 2003
MHR RTP	Mental Health Residential Rehabilitation Treatment Program	October 22, 2008
MHS	Mental Health Suite	March 24, 2011
MHS	Military Health System	Added prior to March 2003
MHTC	Mental Health Treatment Coordinator	August 23, 2011
MHV	My HealtheVet	June 30, 2003
MHVC	MyHealtheVet Coordinator	December 03, 2014
MHZ	Megahertz	July 21, 2004
MI	Major Initiative	April 23, 2014
MI	Myocardial Infarction	December 14, 2016
MI	motivational interviewing	December 15, 2016
MIB	Management Information Base	June 08, 2005
MIB	Medical Information Bus (standard)	Added prior to March 2003
MICHM	Mental Health Intensive Case Management	May 01, 2014
MICU	Medical Intensive Care Unit	March 12, 2009
MID	Middle	August 14, 2014
MIL	Medication Image Library	July 21, 2014
MIMC	Medical Information Management Committee	Added prior to March 2003
MIME	Multimedia Internet Mail Extensions	Added prior to March 2003
MIN	minute	October 22, 2015
MINX	Management Information Exchange System (Delta Solutions Inc.)	July 27, 2009
MIO	Medical Informatics Office	April 27, 2010
MIPR	Military Interdepartmental Purchasing Request	July 21, 2004
MIRECC	Mental Illness Research, Education and Clinical Center	Added prior to March 2003
MIRMO	Medical Information Resources Management Office	Added prior to March 2003
MIS	Management Information Systems	Added prior to March 2003
MISD	Management Information Software Development	Added prior to March 2003
MISN	Memorial Integrated Service Network	July 30, 2015
MISS	Medical Information Security Service	Added prior to March 2003
MIT	Means Indicator Test	Added prior to March 2003
MITA	Medicaid Information Technology Architecture	January 14, 2008
ML	milliliter	April 21, 2016
MLQ	Mid lower quadrant of abdomen	August 04, 2014
MMAD	Mass Median Aerodynamic Diameter	March 23, 2009

MMI	Master Member Index	July 21, 2004
MMP	Medical Monitoring Project	October 30, 2006
MMPI	Minnesota Multiphasic Personality Inventory	April 17, 2014
MMS	Medical Media Service	October 14, 2008
MMSO	Military Medical Support Office	Added prior to March 2003
MMU	Mobile Medical Unit	June 16, 2015
MNE	Military Noise Exposure	March 01, 2010
MO	Medical Officer	July 21, 2004
MO.	Month	January 21, 2016
MOA	Memorandum of Agreement	May 13, 2010
MOB	Make-or-Buy	May 13, 2010
MOCHA	Medication Order Check Healthcare Application	April 04, 2011
MOD	Medical Officer of the Day	Added prior to March 2003
MOD	month of death	April 01, 2014
MODEM	Modulator/Demodulator	July 21, 2004
MOE	Measures of Effectiveness	May 07, 2014
MOF	Meta-Object Facility	July 21, 2004
MOLAP	Multidimensional On-Line Analytical Processing	July 21, 2004
MOM	Message Oriented Middleware	June 08, 2005
MON	Monday	August 14, 2014
MOP	Measures of Performance	May 07, 2014
MOPH	Military Order of the Purple Heart	October 31, 2011
MOR	Missed Opportunity Rate	August 21, 2014
MORC	Mobile Outreach Clinic	Added prior to March 2003
MOS	Military occupation specialty	April 23, 2014
MOS	military occupational specialty	April 18, 2014
MOSS	Microsoft Office SharePoint Server	December 14, 2010
MOU	Memorandum of Understanding	July 21, 2004
MOW	MEALS ON WHEELS	April 21, 2016
MP	Medication Profile	April 20, 2010
MP	Manual Part	May 23, 2006
MPA	Merit Promotion Announcement	October 18, 2010
MPCR	Monthly Program Cost Report	January 25, 2005
MPCR3	Monthly Program Cost Report 3	April 23, 2014
MPD	Minimal Patient Dataset	Added prior to March 2003
MPEG	Moving Picture Experts Group	June 08, 2005
MPHISE	Medical Public Health Information Sharing Environment (Work Group)	April 20, 2009
MPI	Lexiscan MPI	February 14, 2012
MPI	Master Patient Index	Added prior to March 2003

MPI /CIRN-PD	Master Patient Index/CIRN Patient Demographics	Added prior to March 2003
MPI /DQ (OLD)	Master Patient Index/Data Quality (See IM DQ)	February 22, 2005
MPI /PD	Master Patient Index/Patient Demographics	Added prior to March 2003
MPIL	Master Patient Information Locator	Added prior to March 2003
MPL	Master Patient Locator	Added prior to March 2003
MPLS	Multiprotocol Label Switching	July 27, 2009
MPR	Monthly Performance Report	October 21, 2009
MPR	Monthly Progress Review	June 06, 2014
MPS	Memorial Programs Service	April 03, 2014
MQAS	Management Quality Assurance Service	March 20, 2008
MR&OP	Mission Requirements & Performance Outcomes	May 07, 2014
MRA	Medicare Remittance Advice	Added prior to March 2003
MRB	Merit Review Board	Added prior to March 2003
MRCP	Magnetic Resonance Cholangiopancreatography	March 26, 2009
MRI	Magnetic Resonance Imaging	Added prior to March 2003
MRP	My Recovery Plan	April 03, 2014
MRR	medical record request	December 15, 2016
MRS	Medical Research Service	Added prior to March 2003
MRS	Military Records Specialist	May 07, 2014
MRSA	Methicillin-Resistant Staphylococcus Aureus	April 25, 2007
MRT	Moral Reconation Therapy	May 24, 2010
MRTS	Message Routing and Translation System	Added prior to March 2003
MRWG	Medical Records Working Group	March 04, 2009
MS IE	Microsoft Internet Explorer	July 21, 2004
MS IIS	Microsoft Internet Information Server	July 21, 2004
MS&C	Medical Support and Compliance	May 19, 2015
MS&N	Medical Surgical & Neurological	April 06, 2007
MSA	Medical Support Assistant	November 04, 2011
MSAC	Medical Situational Awareness & Command and Control	Added prior to March 2003
MSC	military service coordinator	June 14, 2011
MSDS	Military Service Data Sharing	December 16, 2011
MSDS	Medical Supply Distribution Section	March 08, 2010
MSDS	Material Safety Data Sheet	January 11, 2005
MSE	Managed Self-Enrollment	January 21, 2016
MSF	Managing Scanning Failures	March 20, 2008
MSI	Master Subject Index	Added prior to March 2003
MSICU	Medical Surgical Intensive Care Unit	August 14, 2014
MSN	Memorial Service Network	December 15, 2008
MSO	Medical Sign-On	September 18, 2008
MSOC	Multi-Specialty Outpatient Clinic	April 18, 2014
MSP	Motor, Sensory & Pulses	August 21, 2014

MSPE	Medical Student Performance Evaluation	April 21, 2016
MSPV	Med/Surg Prime Vendor	October 29, 2015
MSQCSR	Milestone Schedule Quarterly Congressional Status Report	May 03, 2007
MSR	Medical Speech Recognition	December 15, 2016
MST	Military Sexual Trauma	Added prior to March 2003
MSV	Maintenance and Support of VistA	July 06, 2009
MTC	Major Transaction Class	March 31, 2010
MTF	(DoD) Military Treatment Facility	April 11, 2007
MTF	Medical Treatment Facility/Facilities	Added prior to March 2003
MTFB	Mean Time Between Failures	July 21, 2004
MTM	Medication Therapy Management	February 13, 2006
MTP	Master Test Plan	October 01, 2003
MTSA	Master Telehealth Service Agreement	September 23, 2014
MTX	Methotrexate	December 15, 2016
MU	Meaningful Use	May 07, 2014
MU	Monitoring Unit	July 21, 2004
MUGA	Multiple Gated Acquisition	Added prior to March 2003
MUMPS	Massachusetts General Hospital Utility Multi-Programming System	Added prior to March 2003
MUQ	Mid upper quadrant of abdomen	August 04, 2014
MVA	Motor Vehicle Accident	June 25, 2014
MVAC	Medical VA Center	April 23, 2014
MVAC	MyVA Advisory Committee	March 23, 2015
MVAHCS	Minneapolis Veterans Administration Health Care System	April 17, 2015
MVC	Mobile Vet Centers	April 03, 2014
MVC	MyVeHU Campus	May 07, 2014
MVI	Master Veteran Index	August 25, 2010
MVP	Million Veteran Program	July 30, 2015
MVR	Master Veteran Record	Added prior to March 2003
MWAPI	M Windows Application Program Interface	Added prior to March 2003
MWB	Messaging Work Bench	December 14, 2005
MWRS	Material Weakness Remediation Support	December 15, 2016
MYP	Multi-year Programs	May 13, 2010
N		top
N/V	nausea/vomiting	August 04, 2014
N/V/D	nausea/vomiting/diarrhea	December 03, 2014
NAA	National Association of Area Agencies on Aging	Added prior to March 2003
NAA	Next Available Appointment	January 08, 2009
NABS	Normal Active Bowel Sounds	April 23, 2014
NAC	National Acquisition Center	Added prior to March 2003
NACI	National Agency Check w/Inquiries	July 06, 2009

NACVSO	National Association of County Veteran Service Officers	April 30, 2009
NAD	No acute distress	November 30, 2009
NADL	Native American Direct Loan	October 04, 2010
NAGE	National Association of Government Employees	Added prior to March 2003
NAGIS	National Advisory Group for Information Security	Added prior to March 2003
NAGMA	Non anion gap metabolic acidosis	January 21, 2016
NAI	Network Associates Incorporated	Added prior to March 2003
NAMMCAL	North American Medical Management California	February 18, 2010
NANP	North American Numbering Plan	Added prior to March 2003
NAO	Network Authorization Office	July 06, 2010
NAOU	Narcotics Area Of Use	November 01, 2005
NAPA	National Academy of Public Administration	Added prior to March 2003
NARA	National Archives and Records Administration	Added prior to March 2003
NARS	National Automated Response System	July 21, 2004
NAS	Network-addressable Storage	July 21, 2004
NAS	National Academy of Sciences	Added prior to March 2003
NASA	National Aeronautics and Space Administration	Added prior to March 2003
NASUA	National Association of State Units on Aging	Added prior to March 2003
NASVH	National Association of State Veterans Homes	September 20, 2010
NAT	Network Address Translation	Added prior to March 2003
NATREM	NATional REMinders Development Account	July 30, 2015
NATS	NETWORK ACTION TRACKING SYSTEM	April 23, 2014
NAVACOS	National Association of VA Chiefs of Staff	Added prior to March 2003
NAVAP	National Association of VA Physicians	Added prior to March 2003
NBC	National Biodefense Campus	April 11, 2007
NBS	National Bureau of Standards	Added prior to March 2003
NC	National Cemetary	Added prior to March 2003
NC	nasal cannula	September 04, 2015
NCA	National Capital Area	Added prior to March 2003
NCA	National Cemetery Administration	March 27, 2007
NCAO	National Cemetery Area Office	Added prior to March 2003
NCAT	Neurocognitive Assessment Tool	December 01, 2009
NCC	National Call Center	April 17, 2014
NCCAM	National Center for Complementary and Alternative Medicine	August 14, 2008
NCCC	National Clozapine Coordinating Center	December 11, 2007
NCCC	National Center for Cost Containment	Added prior to March 2003
NCCHV	National Call Center for Homeless Veterans	October 31, 2011
NCCIP	National Cardiovascular Care Improvement Program	April 16, 2003
NCCMH	North-side Community Care Mental Health	October 14, 2008
NCCPAC	North Central Consolidated Patients Account Center	November 13, 2015

NCD	National Center for Documentation	Added prior to March 2003
NCFC	National Customer Feedback Center	Added prior to March 2003
NCHC	National Criminal History Check	May 01, 2014
NCHCS	Northern California Health Care System	Added prior to March 2003
NCHPDP	National Center for Health Promotion and Disease Prevention	Added prior to March 2003
NCHS	National Center for Health Statistics	Added prior to March 2003
NCI	National Cancer Institute	August 10, 2010
NCIC	National Crime Information Center	December 14, 2016
NCID	Numeric Concept Identifier	July 21, 2004
NCIS	National Center for Information Security	Added prior to March 2003
NCITS	National Committe For Information Technology Standards	July 21, 2004
NCL	National Control Listing	July 21, 2004
NCMD	National Card Management Directory	Added prior to March 2003
NCMHC	National Center on Minority Health and Health Disparities www.ncmhd.nih.gov	September 08, 2008
NCO	Network Contracting Office	April 18, 2014
NCOA	National Change of Address	April 16, 2008
NCOD	National Center for Organization Development	September 23, 2008
NCOF	no claim on file	December 15, 2016
NCP	National Center for Health Promotion and Disease Prevention	April 23, 2014
NCPDP	National Council for Prescription Drug Programs	Added prior to March 2003
NCPS	Natinal Center for Patient Safety	Added prior to March 2003
NCPS	National Center for Patient Safety	December 15, 2016
NCQA	National Committe for Quality Assurance	July 21, 2004
NCS	National Cemetary System	Added prior to March 2003
NCS	National Contract Service	February 18, 2010
NCVHS	National Committee on Vital & Health Statistics	Added prior to March 2003
ND	National Director	February 18, 2010
ND	Network Director	February 18, 2010
NDA	Non-Disclosure Agreement	May 07, 2014
NDAA	National Defense Authorization Act	August 03, 2011
NDAA	National Defense Authorization Act	Added prior to March 2003
NDBI	National Data Base Integration (Team)	Added prior to March 2003
NDC	National Drug Code	Added prior to March 2003
NDC	National Data Center	May 12, 2010
NDCP	National Data Center Program	October 10, 2006
NDE	National Data Extract	April 23, 2014
NDF	National Drug File	Added prior to March 2003
NDF-RT	National Drug File-Reference Terminology	Added prior to March 2003
NDI	Non-Developmental Item	January 02, 2008
NDMS	National Disaster Medical System	Added prior to March 2003

NDNQI	National Database of Nursing Quality Indicators	September 23, 2014
NDPP	National Director's Performance Plan	April 18, 2014
NDR	National Drug File	Added prior to March 2003
NDS	National Data Systems	February 10, 2004
NDS	Naming Directory Service	March 23, 2007
NEAR	New Enrollee Appointment Request	June 25, 2014
NEC	Naval Enlisted Code	April 30, 2014
NECC	Nurse Educator Caritas Coach	December 15, 2016
NEDSS	National Electronic Data Surveillance System	Added prior to March 2003
NEG	Negative	August 04, 2014
NeHC	National eHealth Collaborative	February 03, 2009
NEMRT	National Emergency Management Response Team	December 28, 2011
NEMT	National Emergency Management Team	Added prior to March 2003
NEO	New Employee Orientation	March 05, 2009
NEPEC	Northeast Program Evaluation Center	October 02, 2007
NEURO	Neurology or Neurologic	August 14, 2014
NEWT	Nessus Enterprise Web Tool	May 19, 2015
NF	National Formulary	June 21, 2010
NF/SG	North Florida/South Georgia	March 20, 2008
NFPO	National Fee Program Office	February 22, 2011
NFS	Nutrition and Food Service	June 23, 2008
NFS	Network File System	July 21, 2004
NG	nasogastric	August 04, 2014
NGI	Next Generation Internet	Added prior to March 2003
NGIT	Northrup Grumman Information Technology	July 29, 2004
NGL	Nationwide Gravesite Locator	June 14, 2011
NGTD	No Growth To Date	April 23, 2014
NHC	Nursing Home Care	Added prior to March 2003
NHCC	Naval Health Clinic Charleston	October 22, 2015
NHCPD	National Health Care Practitioners Database	February 10, 2004
NHCU	Nursing Home Care Unit	Added prior to March 2003
NHD	National Help Desk	Added prior to March 2003
NHE	National Health Exchange	Added prior to March 2003
NHE	Network Health Exchange	April 11, 2007
NHI	Nationwide Health Information	October 25, 2011
NHIE	National Health Information Exchange	December 14, 2009
NHII	National Health Information Infrastructure (WG of NCVHS)	Added prior to March 2003
NHIO	National Health Information Organization	March 27, 2006
NHPI	National Health Plan Identifier	February 14, 2012
NHPP	National Health Physics Program	June 29, 2005

NHPPD	nursing hours per patient day	May 14, 2014
NHRIC	National Health Related Items Code	December 08, 2011
NHSN	National Healthcare Safety Network	October 14, 2008
NIC	Network Interface Card	November 16, 2011
NIC	Non-Institutionalized Care	February 02, 2011
NICMO	non-ischemic cardiomyopathy	October 22, 2015
NIDDM	Non insulin diabetes Melitis	September 23, 2014
NIEM	National Information Exchange Model	April 10, 2014
NIF	National Item File	September 28, 2005
NIGMS	National Institute General Medicine Service	Added prior to March 2003
NIH	National Institutes of Health	Added prior to March 2003
NIHI	National Initiative for Health Care Informatics	Added prior to March 2003
NII	National Information Infrastructure	July 21, 2004
NIIS	Nursing Integrated Information System	June 29, 2005
NIMH	National Institute of Mental Health	Added prior to March 2003
NIMS	National Incident Management System	April 17, 2014
NIPRNET	uNclassified Internet Protocol Router Network	April 18, 2014
NIRC	Non-Institutional Respite Care	April 18, 2014
NIRMO	National Initiative to Reduce Missed Opportunities	July 21, 2014
NIS&T	National Institute for Science and Technology	Added prior to March 2003
NISO	(Network) Information Security Officer	May 03, 2011
NIST	National Institute of Standards and Technology	Added prior to March 2003
NIT	Nursing Intervention Team	April 03, 2014
NITRD	Networking and Information Technology Research and Development	August 22, 2011
NKDA	No Known Drug Allergies	October 31, 2007
NLB	National Leadership Board	Added prior to March 2003
NLC	National Leadership Council	December 28, 2011
NLM	National Library of Medicine	Added prior to March 2003
NLN	National League for Nursing	April 11, 2007
NLT	National Laboratory Test	Added prior to March 2003
NLT	no later than	December 15, 2016
NLTF	VA National Laboratory Test File	Added prior to March 2003
NMCSD	Naval Medical Center San Diego	April 11, 2007
NMDC	National Media Development Center	Added prior to March 2003
NMDS	National Mobile Device Support	December 14, 2016
NME	National Medical Enterprises	Added prior to March 2003
NMEA	Non Mail Enabled Administrator	April 23, 2014
NMHIP	National Mental Health Improvement Program	Added prior to March 2003
NMIMC	Naval Medical Information Management Center	Added prior to March 2003
NMR	Nuclear Magnetic Resonance	Added prior to March 2003

NMS	NeuroMusculoSkeletal	February 06, 2015
NNEI	National Nursing Education Initiative	April 23, 2014
NNMC	National Naval Medical Center	December 13, 2006
NNPO	National Non-VA Program Office	February 06, 2015
NNTTP	Network News Transport Protocol	July 21, 2004
NOA	Notice of Appeal	Added prior to March 2003
NOA	Notice of Awards	May 13, 2010
NOAA	National Atmospheric Administration	December 14, 2016
NOAC	Nature of Action Code	September 27, 2010
NOAVA	Nationwide Office Automation for Veterans Affairs	Added prior to March 2003
NOC	Network Operations Center	Added prior to March 2003
NOD	Notice of Disagreement	July 21, 2004
NOD	Notice of Death	December 28, 2011
NOD	Nursing Officer of the Day	March 02, 2009
NOI	No Other Inquiries	April 12, 2010
NOIS	National On-line Information System	Added prior to March 2003
NOK	Next of Kin	July 21, 2004
NOPP	Notice of Privacy Practices	April 17, 2014
NOS	Not Otherwise Specified	October 31, 2007
NOV	Notice of Value	July 21, 2004
NP	Nurse Practitioner	June 08, 2010
NPA	Nasal Pharyngeal Airway	August 04, 2014
NPCD	National Patient Care Database	Added prior to March 2003
NPCDB	National Patient Care Database	July 20, 2011
NPDB	National Practitioner Data Bank	Added prior to March 2003
NPDR	nonproliferative diabetic retinopathy	December 22, 2005
NPI	National Provider Identifier	June 13, 2006
NPM	National Patch Module	Added prior to March 2003
NPO	Nothing by mouth, pt may not eat or drink	August 04, 2014
NPOD	night Psychiatrist on duty	July 25, 2014
NPOD	Night Psychiatrist on duty, usually for ER eval of pt	July 25, 2014
NPPD	National Prosthetic Patient Database	June 28, 2004
NPPES	National Plan and Provider Enumeration System	October 02, 2007
NPR	National Performance Review	Added prior to March 2003
NPRC	National Personnel Records Center	July 21, 2004
NPRM	Notice of Proposed Rule Making	Added prior to March 2003
NPS	Nursing Professional Services	July 20, 2009
NPS/SRD	National Provider System/System Requirements Definition	Added prior to March 2003
NPSB	Nurse Professional Standards Board	Added prior to March 2003
NPTF	New Patient Treatment File	Added prior to March 2003

NQC	National Quality Council	October 01, 2008
NRB	Not Receiving Benefits	December 15, 2016
NRC	Nuclear Regulatory Commission	Added prior to March 2003
NRD	National Resource Directory	February 23, 2010
NRD	Next Review Date/Due	March 08, 2011
NRDC	National Rural Development Council	Added prior to March 2003
NREN	National Research and Education Network	July 21, 2004
NRM	Non-recurring Maintenance	September 12, 2007
NRMIS	National Resources Management Information System	Added prior to March 2003
NRSC	National Radiation Safety Committee MML	April 11, 2007
NS	Normal Saline IV fluid	August 14, 2014
NS	Normal Saline	August 14, 2014
NSA	National Security Agency	Added prior to March 2003
NSC	Non-Service Connected	Added prior to March 2003
NSC	Non-Service Connected	May 30, 2007
NSC	Network Support Center	April 24, 2006
NSC	Nuclear Sclerotic Cataract	December 15, 2016
NSCC	Now Show Clinic Cancellation Rate	December 15, 2016
NSD	National Service Desk	April 18, 2014
NSD	National Service Desk	April 10, 2014
NSLI	National Service Life Insurance	July 14, 2010
NSO	National Surgery Office	December 15, 2016
NSOC	Network and Security Operations Center	October 31, 2007
NSOC	Network Security Operations Center	April 23, 2014
NSP	Not Separately Priced	June 25, 2014
NSPD	National Security Presidential Directive	April 17, 2014
NSQIP	National Surgical Quality Improvement Program	Added prior to March 2003
NSR	Normal Sinus rythm	August 14, 2014
NSR	New Service Request	August 17, 2004
NSTIC	National Strategy for Trusted Identities in Cyberspace	June 14, 2011
NT	New Technology	Added prior to March 2003
NTA	National Training Academy	August 04, 2014
NTE	Network Health Exchange	Added prior to March 2003
NTE	Not-to-Exceed	May 13, 2010
NTEO	National Training & Education Office	Added prior to March 2003
NTF	No Trouble Found	May 27, 2016
NTIA	National Telecommunications Information Administration	Added prior to March 2003
NTIS	National Technical Information Service	Added prior to March 2003
NTP	National Training Priorities	Added prior to March 2003
NTP	Network Time Protocol	March 07, 2008
NTP	National Teleradiology Program	December 15, 2008

NTR	Notice to Report	March 31, 2010
NTRT	New Term Rapid Turnaround	June 30, 2003
NTS	Near-Term Solution	Added prior to March 2003
NUCC	National Uniform Claim Committee	October 02, 2007
NUMI	National Utilization Management Integration	May 27, 2008
NUMI	National Utilization Management Integration	April 23, 2014
NVC	National Verification Center	April 18, 2014
NVCC	Non-Va Care Consult	April 23, 2014
NVCC	Non VA Care Coordination	February 06, 2015
NVDRS	National Violent Death Reporting System	June 02, 2010
NVLD	Non-Verbal Learning Disability	January 21, 2016
NVO	National Veterans Outreach	May 01, 2014
NVS	National VISTA Support	Added prior to March 2003
NVSAAB	National Veterans Service Advocates Advisory Board	April 27, 2009
NVSBE	National Veterans Small Business Engagement	January 21, 2016
NVW	VistA Web	April 17, 2014
NVW	National Vista Web server	April 23, 2014
NWB	NWB	December 21, 2011
NwHIN	Nationwide Health Information Network	April 26, 2011
NWIHCS	Nebraska Western Iowa Health Care System	July 14, 2010
NWQ	National Work Queue	May 19, 2015
NYHHCS	New York Harbor Healthcare System	March 20, 2008
O		top
O&M	Operation and Maintenance	May 13, 2010
O&M	Orientation and Mobility	November 15, 2010
O&M	Operations and Maintenance	July 26, 2004
O&P	Orthotics & Prosthetics	January 21, 2016
O2	Oxygen	August 14, 2014
O2 SAT	Oxygen Saturation	August 14, 2014
OA	Office of Audit	March 31, 2010
OA	Office Automation	Added prior to March 2003
OA&F	The Office of Administration and Facilities	December 14, 2016
OA&L	Office of Acquisitions and Logistics	October 25, 2011
OAA	Office of Academic Affiliations	June 21, 2010
OAA	Office of Academic Affairs	Added prior to March 2003
OAB	over active bladder	June 16, 2015
OAEM	Office of Asset Enterprise Management	Added prior to March 2003
OAI	Organizational Assessment Inventory	March 18, 2009
OAIC	Office of Accountability, Integrity and Compliance	April 30, 2014
OAL	Office of Acquisition and Logistics	March 15, 2010

OALC	Office of Acquisition, Logistics, and Construction	April 27, 2009
OAO	Office of Acquisition Operations	April 23, 2014
OAP	Operational Acceptance Plan	May 10, 2010
OAS	Office of Acquisition SharePoint - MOSS 2010	May 27, 2016
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs	Added prior to March 2003
OASDI	Old Age, Survivors & Disability Insurance	March 14, 2005
OASIS	Organization for the Advancement of Structured Information Standards	June 30, 2003
OBC	Office of Business Continuity	February 06, 2015
OBE	Online Booking Engine	July 06, 2010
OBO	Office of Business Oversight	April 07, 2009
OBP	Optimized Business Process	May 07, 2014
OBPI	Office of Business Process Integration	April 10, 2014
OBRA	Omnibus Budget Reconciliation Act	April 10, 2003
OBS	Organizational Breakdown Structure	July 26, 2004
OBS	Offboard Server	Added prior to March 2003
OC	Office of Construction	Added prior to March 2003
OCC	Office of Care Coordination	October 10, 2006
OCCC	Office of Clinical Consultation & Compliance	April 07, 2011
OCCM	Office of Communications and Case Management	December 15, 2016
OCI	Organizational Conflict Of Interest	May 13, 2010
OCIO	Office of Chief Information Officer	Added prior to March 2003
OCIOII	Office of the CIO Infrastructure Improvements	Added prior to March 2003
OCIS	Office of Cyber and Information Security	January 12, 2004
OCLA	Office of Congressional & Legislative Affairs	March 22, 2004
OCM	Outlines in Clinical Medicine	Added prior to March 2003
OCM	Organizational Change Management	December 15, 2016
OCMO	Office of the Chief Medical Officer (DoD)	May 07, 2014
OCN	Oncology Certified Nurse	July 28, 2010
OCO	Overseas Contingency Operation	March 25, 2009
OCONUS	Outside Continental United States	December 15, 2016
OCP	Oral Contraceptive Pill	April 21, 2016
OCR	Optical Character Reader	Added prior to March 2003
OCR	Office for Civil Rights	April 27, 2004
OCS	Office of Cyber Security	Added prior to March 2003
OCS	Office Communicator Server	October 12, 2010
OCWG	Organizational Consistency Working Group	July 21, 2008
OD&E	Office of Organization Development and Engagement	October 06, 2016
OD, OS, OU	Oculus Dexter, Oculus Sinister, Oculus Uterque	October 22, 2015
ODA	Operating Division of Audit	Added prior to March 2003
ODBC	Open Database Connectivity	July 26, 2004

ODC	Other Direct Costs	October 01, 2008
ODI	Office of Diversity and Inclusion	December 16, 2008
ODM&T	Office of Data Management and Telecommunications	Added prior to March 2003
ODS	Operational Data Store	July 26, 2004
ODS	Office of Dietary Supplements www.od.nih.gov	August 14, 2008
OE	Other Equipment	June 12, 2006
OE/RR	Order Entry/Results Reporting	Added prior to March 2003
OEA	Office of Enterprise Architecture	April 11, 2007
OEA&I	Office of the Enterprise Architecture and Innovation	August 12, 2009
OEAM	Office of Enterprise Architecture Management	January 14, 2008
OEC	Office of Enterprise Communications	April 15, 2014
OED	Office of Enterprise Development (see PD)	March 28, 2011
OEDCA	Office of Employment Discrimination Adjudication	October 01, 2014
OEF	Operation Enduring Freedom	May 13, 2004
OEF/OIF	Operation Enduring Freedom/Operation Iraqi Freedom	November 05, 2008
OEM	Office of Emergency Management	February 09, 2011
OEMP	Office of Emergency Medical Preparedness	Added prior to March 2003
OERR	Order Entry Results Reporting	April 01, 2008
OERS	Officer Evaluation Reports	December 14, 2016
OESS	Office of E-Health Standards and Services	June 02, 2005
OF	Optional Form	July 26, 2004
OF	Office of Facilities	Added prior to March 2003
OFFM	Office of Federal Financial Management	July 27, 2009
OFIRM	Office of Finance and Information Resources Management	April 30, 2014
OFMR	Office of Financial Management Reports	December 15, 2016
OFP	The Office of Financial Policy	October 04, 2010
OFPIAR	Office of Financial Process Improvement and Audit Readiness	November 30, 2009
OFPP	Office of Federal Procurement Policy	May 13, 2010
OG	orogastric	August 04, 2014
OGA	Other Government Agencies	July 26, 2004
OGC	Office of General Counsel	November 21, 2007
OGD	Open Government Directive	February 18, 2010
OHI	Office of Health Information	April 15, 2009
OHRA	Office of Human Resources and Administration	April 23, 2014
OHRM	Office of Human Resources Management	Added prior to March 2003
OHRO	Office of Human Reserach Oversight	May 08, 2003
OHRS	Occupational Health Record-keeping System	February 25, 2008
OHS	Office of HIPAA Standards	June 02, 2005
OHT	Open Health Tools	December 17, 2007
OHT	Office of Health Care Transformation	April 30, 2014

OI	Office of Information (see OHI)	April 15, 2009
OI&T	Office of Information and Technology	June 25, 2014
OIA	Office of Information Assurance	July 26, 2004
OIA	Office of Informatics and Analytics	April 03, 2014
OID	Organizational Identifier	April 30, 2014
OIF	Operation Iraqi Freedom	May 13, 2004
OIFO	Office of Information Field Office	July 26, 2004
OIG	Office of the Inspector General	Added prior to March 2003
OIGG	Office of the Assistant Deputy Under Secretary for Informatics and Information Governance	December 14, 2016
OINQ	Outpatient Inquiry	Added prior to March 2003
OIPT	Overarching Integrated Product Team	April 21, 2008
OIRA	Office of Information and Regulatory Affairs (in OMB)	February 01, 2010
OIRM	Office of Information Resource Management	Added prior to March 2003
OIS	Office of Information Security	September 22, 2011
OITSC	OI Tactical Space Committee	August 15, 2007
OLA	Operation Level Agreement	January 20, 2011
OLAF	Online Approval File	July 26, 2004
OLAP	Online Analytical Processing	January 03, 2005
OLCS	On-Line Certification System	October 31, 2007
OLE	Object Linking and Embedding	June 08, 2005
OLTP	On-Line Transaction Processing	July 26, 2004
OM	Operations Management	June 19, 2007
O-MAT	ORH Management & Analysis Tool	May 27, 2016
OMB	Office of Management and Budget	Added prior to March 2003
OMC	Operations Management Center	July 26, 2004
OMELOS	Observed minus expected length of stay	March 08, 2010
OMG	Object Management Group	Added prior to March 2003
OMHO	Office of Mental Health Operations	April 23, 2014
OMHO	Office of Mental Health Operations	April 30, 2014
OMHO	Office of Mental Health Operations	May 07, 2014
OMHS	Office of Mental Health Services	April 17, 2014
OMI	Office of Medical Inspector	Added prior to March 2003
OMM	Osteopathic Manipulative Medicine	February 06, 2015
OMPF	Official Military Personnel Files	April 18, 2014
OMR	Office of Media Relations	Added prior to March 2003
OMR	Operational Management Review	June 23, 2010
OMT	Osteopathic Manipulative Treatment	February 06, 2015
ONC	Office of the National Coordinator for Health IT (ONC)	March 23, 2015
ONCHIT	Office of the National Coordinator for Health Information Technology	November 30, 2004

OND	Operation New Dawn	May 09, 2011
ONE	Occupational Noise Exposure	March 01, 2010
ONSI	The Office of Nursing Services Informatics	April 13, 2010
OOB	out of bed, pt is safely out of bed	July 25, 2014
OOO	Out Of Office	December 10, 2014
OOORAM	OUT OF OPERATING ROOM AIRWAY MANAGEMENT	July 30, 2015
OOP	Object-Oriented Programming	March 31, 2009
OOPSS	out on pass	July 05, 2011
OOR	Office of Responsibility	October 04, 2010
OOS	Occasion of Service	September 23, 2014
OOS	Other Outpatient Services	September 23, 2014
OP	Outpatient Pharmacy	December 11, 2007
OP	Over Payment	July 30, 2015
OPA	Oral Pharyngeal Airway	August 04, 2014
OPA	Office of Public Affairs	Added prior to March 2003
OPA&I	VBA Office of Performance Analysis & Integrity	February 14, 2012
OPAI	Outpatient Automation Interface	July 25, 2005
OPC (CBC)	Outpatient Clinic (Community-Based Clinic)	July 21, 2004
OPC(ORC)	Outpatient Clinic (Outreach Clinic)	Added prior to March 2003
OPC(ROC)	Outpatient Clinic (Outpatient Clinic located at Veterans Benefit Regional Office)	Added prior to March 2003
OPC(SOC)	Outpatient Clinic (Satellite Outpatient Clinic)	Added prior to March 2003
OPCA	Office of Public and Consumer Affairs	Added prior to March 2003
OPCM	Outpatient Clinic (Mobile Outpatient Clinic)	July 21, 2004
OPCS-4	Office of Population, Censuses and Survey Classification of Surgical Operations and Procedures - 4th revision	September 28, 2005
OPD	outpatient department	April 21, 2016
OPECC	Outpatient Pharmacy Electronic Claims Coordinators	April 23, 2014
OPECC	Outpatient Pharmacy Electronic Claims Coordinators	October 21, 2014
OPES	Office of Productivity, Efficiency, and Staffing	April 14, 2009
OPF	Official Personnel Folder	April 03, 2006
OPHSR	Office of Public Health Surveillance & Research	April 04, 2008
OPIA	Office of Public and Intergovernmental Affairs	July 14, 2010
OPIM	Other Potentially Infectious Materials	April 23, 2014
OPM	Office of Personnel Management	Added prior to March 2003
OPO	Organ Procurement Organizations	April 15, 2014
OPOC	Oakland Park Outpatient Clinic, Florida	March 08, 2006
OPP	Office of Planning and Programs	December 29, 2009
OPP	Office of Policy and Planning	Added prior to March 2003
OPP&P	Office of Policy, Planning and Preparedness	October 25, 2004
OPPE	ONGOING PROFESSIONAL PRACTICE EVALUATION	May 03, 2011

OPPS	Outpatient Prospective Payment System	April 20, 2009
OPQM	Office of Performance and Quality Measures	Added prior to March 2003
OPT	Out Patient Treatment (Records)	December 15, 2016
OPTR	Outpatient Treatment Record	December 15, 2016
OQL	Object Query Language	July 21, 2004
OQP	Office of Quality and Performance	November 18, 2003
ORB	Object Request Broker	Added prior to March 2003
ORC	Outreach Clinic (outpatient clinic under the management of an MC but not physically located in an MC, less than 3,000 visits per year)	Added prior to March 2003
ORCA	Office of Research Compliance and Assurance	July 28, 2003
ORD	Optional Requirements Document	Added prior to March 2003
ORD	Office of Research and Development	March 15, 2010
ORH	Office of Rural Health	March 26, 2009
ORH	Operation Ranch Hand	December 15, 2016
ORM	Object-Relational Mapping	March 31, 2009
ORM	VBA - ORM	April 23, 2014
ORM	Office of Resolution Management	Added prior to March 2003
ORO	Office of Research Oversight	May 07, 2007
ORR	Operational Readiness Review	April 23, 2014
ORT	Operational Readiness Testing	July 06, 2009
ORT	Outreach Reporting Tool	October 29, 2015
ORTHO	Orthopedic (s)	August 14, 2014
ORTHO	Orthopedic (s), or Positional	August 14, 2014
ORTHOSTATIC(S)	Vital sign changes, possibly relating to or caused by positional changes or erect posture.	August 14, 2014
ORTHOSTATS	Pertaining to BP changes with position changes	August 14, 2014
OS	Open System	July 21, 2004
OS	Operating System	July 21, 2004
OS&LE	Office of Security and Law Enforcement	Added prior to March 2003
OS&P	Office of Operations, Security, and Preparedness	June 27, 2011
OSA	Obstructive Sleep Apnea	May 26, 2011
OSD	Office of the Secretary of Defense	April 23, 2014
OSD	operating system deployment	May 19, 2015
OSDBU	Office of Small and Disadvantaged Business Utilization	Added prior to March 2003
OSDEBU	Office of Small and Disadvantaged Business Utilization	April 23, 2014
OSE	Open Systems Environment	July 21, 2004
OSEHRA	Open Source Electronic Health Record Agent	August 31, 2011
OSEHRA	Open Source Electronic Health Record Alliance	December 15, 2016
OSERA	Open Source E-Gov Reference Architecture	June 30, 2003
OSF	Open Systems Foundation	July 21, 2004
OSGLI	Office of Servicemembers Group Life Insurance	April 03, 2014

OSH	Outside hospital	May 07, 2014
OSHA	Occupational Safety and Health Administration	Added prior to March 2003
OSHCA	Open Source Health Care Alliance	Added prior to March 2003
OSI	Open Systems Interconnection	Added prior to March 2003
OSL	Operating Staff Level	May 17, 2010
OSP	Office of Operations, Security and Preparedness	Added prior to March 2003
OSP	Office of Strategic Planning	April 15, 2014
OSPA	Office of Strategic Planning and Analysis	March 26, 2009
OSS	Open Source Software	October 22, 2003
OSTP	Office of Science and Technology Policy	Added prior to March 2003
OSVA	Office of the Secretary of Veterans Affairs	March 26, 2009
OT	occupational therapist	April 23, 2014
OT&E	Operation Test & Evaluation	Added prior to March 2003
OTA	Office of Technology Assessment	Added prior to March 2003
OTA	Opioid Treatment Agreement	December 15, 2016
OTA	open to air	August 11, 2015
OTC	Over-The-Counter (herbals/non-VA meds)	February 10, 2004
OTJ	on the job	October 22, 2015
OTP	One Time Password	April 17, 2014
OTP	Opioid Treatment Program	November 17, 2008
OTS	Off The Shelf	May 04, 2009
OU	Organizational Unit	April 23, 2014
OV	Operational View	April 23, 2014
OV	OperationsI Viewpoint	April 18, 2014
OVH	Ohio Veterans Home	December 14, 2016
OVHC	Office of Veterans Health Communications	June 12, 2007
OWCP	Office of Workers' Compensation Programs	October 31, 2011
P		top
P	Pulse	August 14, 2014
P	Pulse	October 22, 2015
P&C	Purchasing and Contacting	Added prior to March 2003
P&C	Pension & Compensation	February 09, 2011
P&F	Pension & Fiduciary	May 01, 2014
P&LMS	Pathology and Laboratory Medicine Service	March 27, 2006
P&LO	Procurement and Logistics Office	August 19, 2010
P&T	Pharmacy and Therapeutics	August 26, 2005
P&T	Permanent and Total	April 03, 2015
PA	Privacy Act	July 21, 2004
PA	Program Analyst	April 23, 2014
PA	Physician Assistant	October 20, 2006

PA&I	Performance Analysis and Integrity	July 27, 2011
PAB	Policy Advisory Board	Added prior to March 2003
PAC	Premature Atrial Contraction	September 23, 2014
PACE	Performance Analysis Center for Excellence	March 29, 2004
PACMEDNET	Pacific Medical Network	Added prior to March 2003
PACS	Picture Archiving Communication Systems	Added prior to March 2003
PACS	Physical Access Control System	April 23, 2014
PACT	Preservation-Amputation Care and Treatment	Added prior to March 2003
PACT	Patient-Aligned Care Teams	September 20, 2010
PACT	Patient-Aligned Care Teams	September 20, 2010
PACT	Psychosocial Assessment of Candidates for Transplantation	September 03, 2008
PACU	Patient Acute Care Unit	September 12, 2006
PACU	Post Anesthesia Care Unit	August 25, 2010
PAD	Personnel and Accounting Integrated Data	August 30, 2011
PADP	Patient Assessment Document Package	August 16, 2011
PADP	Patient Assessment Document Package	August 16, 2011
PADRECC	Parkinson's Disease Research, Education, and Clinical Centers	March 25, 2009
PAE	Pharmacy Application Environment	July 21, 2004
PAF	Patient Assessment File	Added prior to March 2003
PAHO	Pan American Health Organization	June 12, 2003
PAI	Patient Assessment Instrument	Added prior to March 2003
PAIC	Prosthetics Assessment Information Center	Added prior to March 2003
PAID	Personnel and Accounting Integrated Data System	Added prior to March 2003
PAIRS	Procurement of Automation Information Resource Solutions	Added prior to March 2003
PAIT	Patient Appointment Information Transmission	July 12, 2006
PAO	Program Administration Office	April 23, 2014
PAPR	Powered Air Purifying Respirator	September 23, 2014
PAR	Performance and Accountability Report	March 14, 2007
PARMIN	Population and Resource Management Information Network	Added prior to March 2003
PART	Program Assessment Rating Tool	May 25, 2004
PAS	Program Application Specialist	April 27, 2006
PAS	Planning and Analysis Service	June 02, 2006
PAS	Personnel Accountability System	April 17, 2015
PASS	Pull Aim Squeeze Sweep	September 23, 2008
PATS	Planning, Architecture, Technology and Services	April 15, 2008
PATS	Patient Advocate Tracking System	April 24, 2003
PAVE	Prevention of Amputation in Veterans Everywhere	April 23, 2014
PAVE	Prevention of Amputation in Veterans Everywhere	April 10, 2014
PAVE	Prevention of Amputation in Veterans Everywhere	April 15, 2014
PAVIR	Palo Alto Veterans Institute for Research	March 23, 2015

PAVs	Price Adjustment Vouchers	Added prior to March 2003
PBC	Provided by Client	June 16, 2015
PBI	Performance Base Interview	September 20, 2010
PBM	Pharmacy Benefits Management	Added prior to March 2003
PBM	Policy Based Management	February 06, 2015
PBMS	Performance-based Management System	July 22, 2003
PBO	PMAS Business Office	June 11, 2014
PBP	Performance Based Payments	May 13, 2010
PBRN	Practice-Based Research Networks	June 06, 2014
PBS	Personal Benefit Services	June 06, 2014
PBX	Private Branch Exchange	June 11, 2014
PC	Policy Council	Added prior to March 2003
PC	Personal Computer	Added prior to March 2003
PCA	Patient-Controlled Analgesia	February 25, 2008
PCA	Primary Care Annex	December 15, 2016
PCAC	Program Contracting Activity-Central	August 25, 2010
PCAOB	Public Company Accounting Oversight Board	September 20, 2010
PCAS	Patient Care Administrative Service	July 06, 2009
PCAS	Patient Care Assessment System	June 16, 2015
PCC	Patient Care Coordinator	April 17, 2015
PCC	Patient Centered Care	February 24, 2010
PCC	Polytrauma Call Center	April 11, 2007
PCC	Patient Care Component	Added prior to March 2003
PCC	Policy Coordinating Committee (Agent Orange-VA)	Added prior to March 2003
PCCN	Progressive Care Certified Nurse	April 30, 2014
PCD	Privacy Communications Data	July 21, 2004
PCE	Primary Care Encounter	June 06, 2014
PCE	Patient Care Encounter	Added prior to March 2003
PCGL	Personal Computer Generated Letter	April 10, 2014
PCGL	Personal Computer Generated Letter	April 23, 2014
PCHS	Procurement for Computer Hardware and Software	Added prior to March 2003
PCI	PIV Card Issuance	April 23, 2014
PCI	Percutaneous Coronary Intervention	April 03, 2014
PCI DSS	Payment Card Industry Data Security Standard	July 21, 2009
PCIOl IN GOOD ORDER	posterior chamber intraocular lens in good order	December 20, 2006
PCL PMO	Prosthetics and Clinical Logistics Program Management Office	March 20, 2008
PCM	Polytrauma Case Manager	April 11, 2007
PCM	Plexis Claims Manager	December 15, 2016
PCMH	Patient Centered Medical Home	April 20, 2010
PCMHI	Primary Care Mental Health Integration	April 20, 2010
PC-MHI	Primary Care - Mental Health Integration	April 30, 2014

PCMM	Primary Care Management Module	Added prior to March 2003
PCN	Patient Control Number	December 08, 2010
PCN	Processor Control Number	August 11, 2006
PCO	Procurring Contracting Officer	May 12, 2010
PCO	Procuring Contracting Officer	May 13, 2010
PCO	Publications Control Officer	Added prior to March 2003
PCORI	Patient-Centered Outcomes Research Institute	September 27, 2010
PCOS	Public Contact and Outreach Specialist	August 12, 2009
PCP	PRIMARY CARE PROVIDER	August 08, 2005
PCR	Public Contact Representatives	April 17, 2014
PCS	Patient Care Services	April 27, 2005
PCT	PTSD Clinical Team	June 23, 2010
PCTOC	Primary Care Telehealth Outreach Clinic	July 20, 2011
PD	Product Development (replaces OED)	March 28, 2011
PD	Position Description	July 06, 2010
PD	Police Department	August 04, 2014
PD	Public Domain	Added prior to March 2003
PD	Perferred Date	October 22, 2015
PDA	Personal Digital Assistant	July 21, 2004
PDA	Project Decision Authority	July 21, 2004
PDAS	Principal Deputy Assistant Secretary	July 03, 2007
PDAS I&T	Principal Deputy Assistant Secretary for Information & Technology	May 07, 2014
PDAT	Position Designation System and Automated Tool	May 09, 2011
PDD	Patient Desired Date	August 16, 2011
PDD	Presidential Decision Directive	Added prior to March 2003
PDF	Portable Document Format	July 21, 2004
PDHRA	Post-Deployment Health Reassessment	November 01, 2005
PDI	Personnel Daily Interface	April 23, 2014
PDI	Program Document Identifier	April 23, 2014
PDI	Phosphodiesterase Inhibitor	April 17, 2015
PDL	Personnel Distribution List	May 17, 2010
PDLC	Program Development Life Cycle	July 26, 2010
PDM	Pharmacy Data Management	December 11, 2007
PDQ	Physician's Data Query	Added prior to March 2003
PDR	Preliminary Design Review	Added prior to March 2003
PDR	Preliminary Design Review	May 12, 2010
PDRECC	Parkinson's Disease Research, Education and Clinical Center	November 22, 2005
PDSA	Plan, Do, Study, Act	December 14, 2010
PDTS	Pharmacy Data Transaction System (DoD Pharm System)	July 15, 2003
PDUSB	Principal Deputy Under Secretary for Benefits	April 30, 2014

PDUSH	Principal Deputy Under Secretary of Health	May 07, 2014
PDWS	Patient Discovery Web Service	April 18, 2014
PDX	Patient Data Exchange	Added prior to March 2003
PE	Prolonged Exposure Therapy	April 23, 2014
PE	Preventive Ethics	April 23, 2014
PE	Pulmonary Embolism	July 30, 2015
PEB	Physical Evaluation Board	December 14, 2016
PEBKAC	Problem Exists Between Keyboard And Chair	April 17, 2014
PEBLO	Physical Evaluation Board Liaison Officer	September 05, 2011
PEC	Psychiatric Emergency Clinic	March 09, 2009
PEC	Preventive Ethics Coordinator	April 23, 2014
PECS	Pharmacy Enterprise Customization System	October 05, 2009
PEMS	Patient Education Management System	October 12, 2010
PEO	Program Executive Office	January 05, 2006
PEP	Project Execution Plan	January 20, 2011
PEPS	Pharmacy Enterprise Product System	August 06, 2007
PERC	Patient Education Resources Center	March 24, 2009
PERC	Program Evaluation Resource Center	June 23, 2010
PERC	Patient Education Resource Center	Added prior to March 2003
PERRL	Pupils equal round and reactive to light	April 30, 2014
PERT	Program Evaluation Review Technique	July 21, 2004
PES	Psychiatric Emergency Service	June 06, 2006
PET	Positron Emission Tomography	April 13, 2010
PET	Position Electron Transformation	Added prior to March 2003
PF	Performance Factor	July 22, 2003
PFSS	Patient Financial Services System	Added prior to March 2003
PGD	Program Director	July 21, 2004
PGD	paged, as in paged MD	August 14, 2014
PGEC	Palliative and Geriatrics and Extended Care	April 23, 2014
PGM	Program Manager	April 23, 2014
PGY	Post Graduate Year	December 15, 2016
PHA	Public Housing Authority	October 31, 2011
PHCA	Preventive Health Care Application	Added prior to March 2003
PHF	Patient History File	July 21, 2004
PHI	Protected Health Information	Added prior to March 2003
PHI	Personal Health Identifiers	June 12, 2007
PHIN	Public Health Information Network	June 30, 2003
PHP	Personalized Health Plan	July 18, 2014
PHP	Partial Hospitalization Program	January 03, 2007
PHR	Personal Health Record	April 20, 2006
PHRSS	Payroll and Human Resource Systems Service	November 30, 2009

PHS	Public Health Service	Added prior to March 2003
PI	Prevention Index	February 20, 2007
PI	Partner Integration	June 14, 2011
PIA	Primary Insurance Amount	April 28, 2010
PIA	Privacy Impact Assessment	September 19, 2006
PIB	Performance Improvement Board	Added prior to March 2003
PIC	Personal Information Carrier	Added prior to March 2003
PIC	Performance Improvement Counsel	May 01, 2014
PICC	Peripherally Inserted Central Catheter	November 08, 2010
PICC	A peripherally inserted central catheter is a thin, soft, flexible tube - an intravenous (IV) line.	May 27, 2016
PICD	Property Inventory Control Division	March 08, 2010
PICS	Patient Image Capture Software	March 27, 2006
PICU	Patient Intensive Care Unit	September 12, 2006
PICU	Pediatric intensive care unit	May 01, 2014
PID	Patient Identification	July 21, 2004
PID	Process Identification	July 30, 2015
PIDS	Person Identification Service	Added prior to March 2003
PIE	Personal Information Exchange	April 23, 2014
PIES	Personnel Information Exchange System	July 21, 2004
PIF	Pending Issue File	April 23, 2014
PIF	Pending Issue File	May 07, 2014
PIHCP	Pacific Island Health Care Project	Added prior to March 2003
PII	Patient Information Integration	Added prior to March 2003
PII	Personally Identifiable Information	April 11, 2007
PIICS	VBA Program Integrity & Internal Controls	April 23, 2014
PIMS	Patient Information Management System	Added prior to March 2003
PIN	Personal Identification Number	April 23, 2014
PIO	Process Improvement Opportunity	January 20, 2011
PIP	Prosthetics Inventory Package	June 25, 2014
PIP	Productivity Improvement Program	Added prior to March 2003
PIR	Post Implementation Review	Added prior to March 2003
PIR	Project Initiation Request	April 17, 2014
PIR	Project Initiation Request	April 23, 2014
PIT	Program Integrity Tool	May 14, 2014
PIT	Postgraduate and In-service Training	Added prior to March 2003
PITC	Philadelphia Information Technology Center	October 21, 2011
PIUC	Patient Information Unspecified Content	February 25, 2008
PIV	Personal Identification Verification	December 27, 2006
PIVMATE	Personal Identity Verification Multi Authentication Technical Enforcement (PIVMATE)	December 15, 2016

PJM	Project Manager	June 25, 2014
PJM	Project Manager	June 25, 2014
PKI	Public Key Infrastructure	Added prior to March 2003
PL	Poet Laureate	Added prior to March 2003
PL	Public Law	July 21, 2004
PL	Policy Letter	December 14, 2016
PLAN	Plain Language Action Network	Added prior to March 2003
PLCP	PAPERLESS CLAIM	May 07, 2014
PLE	Pharmacy Legacy Enhancement	December 07, 2011
PLMS	Pathology and Laboratory Medicine Service	November 04, 2009
PLOU	Portfolio Loan Oversight Unit	October 04, 2010
PLQE	Pharmacy Legacy Quarterly Enhancements	June 08, 2009
PLTIB	Planning and Long-Term Issues Board	January 06, 2009
PM	Project Manager	January 23, 2007
PM	Preventative Maintenance	April 17, 2014
PM	Program Manager	December 23, 2003
PM PAR	Program Management Policy, Assessment, and Reporting	November 24, 2010
PM&R	Productivity Measurement and Reporting	Added prior to March 2003
PM&R	Physical Medicine and Rehabilitation	Added prior to March 2003
PMAC	Project Management Advisory Committee	Added prior to March 2003
PMAP	Pain Management Assessment Project	Added prior to March 2003
PMAS	Project Management Accountability System	March 21, 2014
PMAS	Project Management Accountability System	April 23, 2014
PMAS	Program Management Accountability System	July 06, 2009
PMAT	Program Management Accountability Tool	April 23, 2014
PMB	Performance Measurement Baseline	June 25, 2014
PMB	Postmenopausal bleeding	December 14, 2016
PMC	Pension Management Center	March 08, 2010
PMD	Privacy Management Data	July 21, 2004
PMDB	Prevention & Management of Disruptive Behavior	May 07, 2007
PMDD	Premenstrual Dysphoric Disorder	April 18, 2014
PMEF	Primary Mission Essential Function	April 17, 2014
PMF	Presidential Management Fellow	October 21, 2009
PMHX	Prior or previous medical history	April 10, 2014
PMI	Preventive Maintenance Inspection	April 23, 2014
PMI	Project Management Data	July 21, 2004
PMI	Project Management Institute	July 21, 2004
PMI	patient medication information	April 21, 2016
PMIP	Practice Management Implementation Plan	Added prior to March 2003
PMIS	Project Management Information System	July 21, 2004

PMO	Program Management Office	January 05, 2006
PMO	Portfolio Management Office	April 11, 2007
PMOU	Property Management Oversight Unit	October 04, 2010
PMP	Project Management Professional	March 02, 2009
PMP	Project Management Plan	July 21, 2004
PMR	Program Management Review	June 25, 2014
PMR	Private Medical Records	September 04, 2015
PMRF	Performance Measurement Reporting Platform	April 17, 2014
PMRF	Performance Measure Reporting Foundation	April 03, 2014
PMRS	Patient Movement Request System	Added prior to March 2003
PMS	Project Management Service	Added prior to March 2003
PMSC	Project Management Steering Committee	Added prior to March 2003
PMSR	Process Model Summary Report	May 07, 2014
PN	Progress Notes	Added prior to March 2003
PNA	pneumonia	January 12, 2009
PNB	PROSTATE NEEDLE BIOPSY	December 15, 2016
PNC	Penicilin	August 14, 2014
PNCS	Progress Note Construction Set	May 11, 2011
PND	Post Nasal Drip	February 06, 2015
PNM	Price Negotiation Memorandum	May 13, 2010
PNS	Polytrauma Network Sites	April 17, 2008
PO	Purchasing Order	May 12, 2010
PO	Program Office	July 21, 2004
PO	Purchase Order	July 21, 2004
PO	Privacy Officer	August 26, 2004
PO2	pulse oxygen	March 23, 2015
POA	Power of Attorney	July 21, 2004
POA	PIV Only Authentication	April 23, 2014
POA&M	Plans of Action & Milestones	December 15, 2008
POAM	Plan of Action and Milestones	May 03, 2011
POC	PTSD Outpatient Clinic	October 20, 2010
POC	Point of Care	Added prior to March 2003
POC	Plan of Care	July 30, 2015
POCC	Process of Clinnical Care Clerkship	January 21, 2016
POCs	Points of Contact	Added prior to March 2003
POCT	Point of care testing	August 04, 2014
POD	Position on Duty	April 17, 2014
POD	Psychiatrist on Duty	December 15, 2016
POE	Pharmacy Order Enhancement	Added prior to March 2003
POE	Post Occupancy Evaluation	Added prior to March 2003
POE	Power Over Ethernet	February 07, 2011

POE	Personally Owned Equipment	June 25, 2014
POI	Program Oversight and Informatics	April 23, 2014
POID	Personnel Office ID	December 15, 2016
POJO	Plain Old Java Object	June 08, 2005
POLARIS	Planning On-Line Access, Release and Integration Scheduling	December 15, 2016
POM	Program Operations Manual	January 20, 2011
POMA	Patient-Oriented Management Architecture	Added prior to March 2003
POMS	Purchase Order Management System	Added prior to March 2003
POP	Period of Performance	November 29, 2011
POP Server	Post Office Protocol Server	Added prior to March 2003
POS	Point of Sale	Added prior to March 2003
POS	Positive	August 04, 2014
POS	Period of Service	October 05, 2009
POS	place of service	December 15, 2016
POSIX	Portable Operating System Interface	July 21, 2004
POST-MI	Post-Myocardial Infarction	Added prior to March 2003
POTS	Plain Old Telephone Service	Added prior to March 2003
POV	Purpose of Visit	Added prior to March 2003
POW	Prisoner of War	Added prior to March 2003
PP&C	Program Plans & Controls	April 11, 2007
PP&O	Program Planning and Oversight	May 07, 2014
PPACA	Patient Protection and Affordable Care Act of 2010	July 06, 2010
PPBE	Planning, Programming, Budgeting and Execution	May 07, 2014
PPBE	Planning, Programming, Budgeting and Execution	April 23, 2014
PPBE	Planning, Programming, Budgeting and Execution	April 23, 2014
PPBPL	Patients Pending Bed Placement List	May 19, 2015
PPD	pack per day (as in smoking)	December 03, 2014
PPDHA	Pre- and Post-Deployment Health Assessments	October 03, 2005
PPE	Personal Protective Equipment	April 23, 2014
PPE	Property, Plant and Equipment	February 18, 2010
PPI	Privacy-Protected Information	February 27, 2006
PPL	Providers/Patient Linkage EP	Added prior to March 2003
PPM	Personal Property Management	Added prior to March 2003
PPM	Product and Platform Management	August 14, 2014
PPM	Permanent Pace Maker	August 14, 2006
PPO	Program Planning and Oversight	May 07, 2014
PPP	Point to Point Protocol	Added prior to March 2003
PPP	Pharmacy Prescription Practices	Added prior to March 2003
PPR	Per Patient Request	December 21, 2011
PPR	Periodic Performance Review	June 27, 2011

PPS-N	Pharmacy Product System - National	June 14, 2011
PPT	Provider Performed Testing	January 21, 2016
PPV	Pharmaceutical Prime Vendor	February 18, 2010
PQRI	Physician Quality Reporting Initiative	May 24, 2010
PR	Paperless Reimbursement	November 24, 2010
PR	Purchase Requests	February 18, 2010
PR	payer relations	December 15, 2016
PR&MS	Physical Rehabilitation and Medical Services	April 23, 2014
PRA	Paperwork Reduction Act	July 21, 2004
PRA	Patient Record Architecture	Added prior to March 2003
PRB	Project Review Board	Added prior to March 2003
PRC	Polytrauma Rehabilitation Center	April 11, 2007
PRC	Peer Review Committee	June 14, 2011
PRD	Product Requirements Document	July 21, 2004
PRDC	Prosthetics Research and Development Center	Added prior to March 2003
PRE	Pharmacy Re-Engineering	October 08, 2003
PREP	Post-Deployment Rehabilitative and Evaluation Program	April 01, 2014
PREP	POST-DEPLOYMENT REHABILITATION and EVALUATION PROGRAM)	April 10, 2014
PREP	Post-Deployment Rehabilitation & Evaluation Program	May 01, 2014
PRF	Patient Record Flag	September 28, 2005
PRM	Private Medical Records	May 01, 2014
PRM	Partner Relationship Management	November 05, 2008
PRN	Pro Re Nata	June 10, 2003
PROMOTE	Predictive Outcome Model Over Time for Employment	August 16, 2011
PRP	Pro-Rated Person	March 08, 2011
PRPO	Pacific Regional Program Office	Added prior to March 2003
PRR	Product Readiness Review	April 15, 2014
PRRC	Psychosocial Rehabilitation and Recovery Center	February 09, 2007
PRRO	Pharmacy Recruitment and Retention Office	August 12, 2009
PR RTP	Psychiatric Residential Rehabilitation Treatment Program	Added prior to March 2003
PRSS	Prosthetic Statistical System	Added prior to March 2003
PRTR	Potentially Ready to Rate	January 03, 2011
PS	Provider Systems	October 31, 2007
PS	Person Served	May 21, 2003
PSA	Program Support Assistant	July 21, 2004
PSA	Prostate-specific antigen	Added prior to March 2003
PSA	Primary Service Area	July 12, 2006
PSA	Patient Services Assistant	October 14, 2008
PSA	Public Service Announcement	October 20, 2011
PSAS	Prosthetic and Sensory Aids Service	Added prior to March 2003

PSB	Professional Standards Board	November 06, 2007
PSCC	Posterior Subcapsular Cataract	December 15, 2016
PSCPIM	Surgical Provider Staff Cost and Productivity Investment Model	October 22, 2015
PSCT	Polytrauma Support Clinic Team	October 31, 2007
PSD	Person Service Demographics	June 08, 2005
PSETS	Privacy and Security Event Tracking System	April 17, 2014
PSETS	Privacy and Security Event Tracking System	April 17, 2014
PSHC	Purchased Skilled Home Care	April 23, 2014
PSI	Performance Systems International	Added prior to March 2003
PSI	Patient Safety Issue	April 19, 2005
PSI	Potentially Shippable Increment	January 21, 2016
PSIM	Person Service Identity Management	February 16, 2006
PSL	Patient Service Line	October 14, 2008
PSPO	Patient Safety Program Office	November 30, 2009
PSR	PATIENT SERVICE REPRESENTATIVE	April 30, 2014
PSRO	Professional Services Review Organization	Added prior to March 2003
PSS	Patient Satisfaction Survey	Added prior to March 2003
PSSG	Planning Systems Support Group	February 25, 2008
PST	Preliminary System Testing	Added prior to March 2003
PSWG	Patient Safety Work Group	December 06, 2005
PSWN	Public Safety Wireless Network	Added prior to March 2003
PSYCH	Psychiatry or Pshychiatric assessment, history, admit, personel, or medications	August 14, 2014
PT	patient	August 04, 2014
PT	physical therapist	April 23, 2014
PT/INR	Prothrombin Time/International Normalized Ratio	August 04, 2014
PTA	prior to arrival	August 14, 2014
PTA	Privacy Threshold Analysis	March 23, 2015
PTC	Patient Transfer Center	February 18, 2010
PTC	Prosthetic Treatment Center	Added prior to March 2003
PTD	Project Tracking Database	May 24, 2011
PTE	PEACE TIME ENLISTED	April 17, 2015
PTF	Patient Treatment File	Added prior to March 2003
PTF	President's Task Force	July 21, 2004
PTI	Permanent Transfer In	July 20, 2010
PTO	Permanent Transfer	September 04, 2015
PTRP	Polytrauma Transitional Rehabilitation Program	October 05, 2009
PTRS	Private Treatment Records	June 16, 2015
PTSD	Post-Traumatic Stress Disorder	Added prior to March 2003
PTT	Partial Thromboplastin Time	August 04, 2014
PUB. L.	Public Law	Added prior to March 2003

PUM	Pharmacy Utilization Management	January 21, 2016
PUM	Pharmacy Utilization Management	January 21, 2016
PUMA	Physician Utilization Managment Advisor	October 05, 2009
PUMT	Pressure Ulcer Monitoring Tool	July 27, 2011
PUPP	PRESSURE ULCER PREVENTION PROTOCOL	April 21, 2016
PV	Primary View	October 02, 2007
PV	Planned Value	July 21, 2004
PVA	Paralyzed Veterans of America	Added prior to March 2003
PVAP	Pre-Vocational Apprenticeship Program	Added prior to March 2003
PVC	Premature Ventricular Contraction	August 04, 2014
PVD	Peripheral Vascular Disease	May 19, 2015
PVHCA	Pacific Virtual Healthcare Application	Added prior to March 2003
PVOD	Peripheral Vascular Occlusive Disease	May 19, 2015
PVP	Permanent Virtual Pipe	June 08, 2005
PVTS	Privacy Violation Tracking System	July 05, 2005
PWA	Project Web Access	November 17, 2011
PWBA	Pension and Welfare Benefits Administration	Added prior to March 2003
PWGH	Principal Working Group on Health	Added prior to March 2003
PWS	Performance Work Statement	March 19, 2007
PWW	Patient Weighted Work	December 15, 2016
Q		top
QA	quality assurance	April 17, 2015
QA	Quality Assurance	Added prior to March 2003
QAR	Quality Assurance Review	Added prior to March 2003
QASP	Quality Assurance Surveillance Plan	July 20, 2010
QBE	Query by Example	Added prior to March 2003
QBL	Qualified Bidders List	May 12, 2010
QBL	Qualified Bidders List	May 12, 2010
QCP	QUALITY CONTROL PLAN	September 04, 2015
QD	Daily	August 14, 2014
QGNC	Quasi-Government Non-Profit Corporation	Added prior to March 2003
QID	Four times daily	April 21, 2016
QIO	Quality Improvement Organization	November 18, 2003
QIS	QuIC Information Systems (Workgroup)	Added prior to March 2003
QITC	Quantico Information Data Center	December 14, 2010
QLE	Qualifying Life Event	October 21, 2014
QMAS	Quality Measurement Advisory Service	Added prior to March 2003
QMI	Quality Management Institute	Added prior to March 2003
QML	Qualified Manufacturers List	May 13, 2010
QMP	Quality Management Plan	May 07, 2014

QOS	Quality of Service	July 21, 2004
QPL	Qualified Parts List	May 13, 2010
QPO	Quality, Performance and Oversight	October 31, 2011
QRDA	Quality Reporting Document Architecture	December 18, 2007
QRT	Quality Review Team	April 23, 2014
QSI	Quality Step Increase	April 23, 2014
QSPP	Quadrennial Strategic Planning Process	April 30, 2014
QSV	Office of Quality, Safety, & Value	April 23, 2014
QUAD	Quadroplegic or Quadrant	August 14, 2014
QUASAR	Quality: Audiology and Speech Pathology Audit & Review	Added prior to March 2003
QUASAR	Quality: Audiology and Speech Analysis and Reporting	June 19, 2007
QUERI	Quality Enhancement Research Initiative	Added prior to March 2003
QuIC	Quality Interagency Coordination Task Force	Added prior to March 2003
QUIC	Quality Improvement Checklist	Added prior to March 2003
R		top
R	Respiration(s)	August 14, 2014
R	Right	August 14, 2014
R	Respiration	October 22, 2015
R&D	Research and Development	May 13, 2010
R&D	Research and Development	Added prior to March 2003
R&DC	Receiving & Distribution Center	December 14, 2016
R&E	Registration and Eligibility	July 21, 2004
R&SS	Recruitment and Staffing Services	April 23, 2014
R/C	Return Call	April 17, 2015
R/E/E M/E	Registration/Eligibility/Enrollment Maintenance/Enhancement (Project)	Added prior to March 2003
R/O OR R/O	rule out	August 04, 2014
R/S	Respectfully Submitted	December 15, 2016
R/T	related to	April 06, 2010
RA	Requirements Analysis	April 12, 2010
RA	Room Air	July 30, 2015
RAC	Resource Allocation Committee	March 01, 2011
RACC	Restricted Access Claims Center	December 03, 2014
RACE	Rescue Activate Confine Extinguish	May 09, 2011
RACI	Responsible Accountable Consulted Informed	July 26, 2010
RAD	Release from Active Duty	July 21, 2004
RAD	Rapid Application Development	Added prior to March 2003
RAD	Resource Access Design	Added prior to March 2003
RAEM	Requirements Analysis and Engineering Management	October 02, 2007
RAFT	Reporting and Analytics Field Training	May 14, 2014
RAG	Research Advisory Group	Added prior to March 2003

RAI /MDS	Resident Assessment Instrument/Minimum Data Set	Added prior to March 2003
RAID	Rapid Application Interface Development	Added prior to March 2003
RAID	Redundant Arrays of Independent Disks	July 21, 2004
RAM	Resource Allocation Model	Added prior to March 2003
RAMMP	Red Tape Reduction	November 13, 2015
RAMP	Reports and Measures Portal	April 23, 2014
RAN	Regional Area Network	June 19, 2006
RAP	RAPTOR	July 30, 2015
RAPM	Reverse Auction Program manager	May 26, 2011
RAS	Remote Access Service	June 08, 2005
RAS	Remote Authentication Service	July 21, 2004
RAS	Referral and Authorization System	October 22, 2015
RASCI	Responsible, Accountable, Support, Consulted, Informed	May 07, 2014
RATS	Recertification Accounting Tracking System	December 15, 2016
RATSR	ESE Risk Analysis and Testing Scope Report	February 14, 2012
RB	Rating Board	December 15, 2016
RBAC	Role-Based Access Control	Added prior to March 2003
RBC	Relationship Based Care	April 07, 2011
RBD	Risk-Based Decision	May 07, 2014
RBPS	Rules Based Processing System	May 01, 2014
RBRVS	Resource Based Relative Value Schedule	Added prior to March 2003
RC	Regional Counsel	April 17, 2014
RC	Resident Commissioner	Added prior to March 2003
RC	Reserve Component	April 30, 2014
RCA	Root Cause Analysis	August 16, 2005
RCE	Responsible Conference Executive	April 15, 2014
RCET	Revenue Cycle Enhancement Team	November 30, 2011
RCF	Residential care facility	December 14, 2016
RCF	Residential Care Facility	December 15, 2016
RCH	Residential Care Home	Added prior to March 2003
RCIT	Rapid Cycle Improvement Team	July 21, 2009
RCN	Reports Control Number	Added prior to March 2003
RCO	Research Compliance Officer	June 16, 2015
RCS	Readjustment Counseling Service	Added prior to March 2003
RCS	Records Control System	Added prior to March 2003
RCT	Religious Compensation Time	August 19, 2011
RD	Registered Dietitian	May 03, 2011
RD	Regional Director	Added prior to March 2003
RDA	Registered Dental Assistant	January 15, 2009
RDAT	Request Remote Patient Data	February 25, 2008

RDBMS	Relational Database Management System	July 21, 2004
RDC	Remote Desktop Connection	December 14, 2010
RDC	Rating Decision Complete	May 01, 2014
RDI	Remote Data Interoperability	August 29, 2005
RDM	Requirements Development and Management	April 23, 2014
RDN	Registered Dietitian Nutritionist	March 23, 2015
RDO	Regional Division Office	Added prior to March 2003
RDP	Remote Desktop Protocol	May 07, 2014
RDPC	Regional Data Processing Center	March 08, 2006
RDS	Remote Dispensing System	May 19, 2015
RDV	Remote Data View	October 15, 2003
RE	(One VA) Registration & Enrollment	April 11, 2007
RE	Requirements Engineering	April 12, 2010
REAP	Research Enhancement Award Program	May 14, 2007
REC	Regional Extension Center	April 28, 2010
RECERT	Recertification	April 17, 2015
RED	Requirements Elaboration Document	May 07, 2014
REDI	Resuscitation Education Initiative	May 07, 2014
REE	Registration, Eligibility & Enrollment	April 12, 2010
REEM&E	Registration/Eligibility/Enrollment Maintenance & Enhancements (Project)	Added prior to March 2003
REF	reference	December 15, 2016
REGO II	Reinventing Government -- Phase II	Added prior to March 2003
REMS	Risk Evaluation and Mitigation Strategies	July 06, 2010
REPS	Restored Entitlement Program for Survivors	April 17, 2014
RES	Requirements Elaboration Specification	April 12, 2010
RESCUE	Remote Enterprise Security Compliance Update Environment	February 18, 2010
RESP	respirations	March 23, 2015
REST	Representational State Transfer	July 30, 2015
RFC	Request For Change	February 06, 2015
RFC	Request for Comments	June 08, 2005
RFCC	Request for Contract Change	April 23, 2014
RFCI	Request for Contract Increase	June 02, 2010
RFD	Veterans Benefits Management System - Awards	September 23, 2014
RFD	Ready For Decision	March 23, 2015
RFE	Request for Evaluation	Added prior to March 2003
RFI	Request For Information	Added prior to March 2003
RFID	Radio Frequency Identification	July 21, 2004
RFP	Request for Proposal	Added prior to March 2003
RFP	Request for Proposal	May 12, 2010
RFP	Request for Proposal	May 13, 2010

RFQ	Request for Quotation	May 13, 2010
RFQ	Request for Quotation	July 21, 2004
RFTOP	Request for Task Order Proposal	February 18, 2010
RHC	Rural Health Clinic	September 04, 2015
RHIA	Registered Health Information Administrator	Added prior to March 2003
RHIO	Regional Health Information Organization	March 28, 2006
RHIT	Registered Health Information Technician	July 06, 2010
RHPI	Rural Health Professions Institute	April 23, 2014
RHVHH	Rocky Hill Veteran's Home & Hospital	February 16, 2011
RIC	Receiver In the Canal	April 23, 2014
RIDES-E	Remote Information Data Entry System - Enhanced (DoD's system)	May 27, 2016
RIF	Reduction In Force	Added prior to March 2003
RILO	Region IT Logistic Officer	April 23, 2014
RIM	Research in Motion	October 06, 2011
RIM	Reference Information Model	July 21, 2004
RIMS	Records Inventory Management System	July 30, 2015
RISE	Revenue Improvement and Systems Enhancements	April 15, 2010
RISO	Regional Information Security Officer	Added prior to March 2003
RITPO	Resources Information Technology Program Office (DoD acronym)	October 22, 2003
RIV	Remote Image Views	August 17, 2005
RLC	Regional Loan Centers	July 14, 2010
RLQ	Right lower quadrant of abdomen	August 04, 2014
RLS	Record Locator Service	January 14, 2008
RM	Requirements Management	January 27, 2006
RM	Risk Management	July 21, 2004
RM PLAN	Risk Management Plan	June 27, 2011
RMC	Resource Management Council	February 18, 2010
RMC	Records Management Center	Added prior to March 2003
RME	Reusable Medical Equipment	May 24, 2011
RMEC	Regional Medical Education Center	Added prior to March 2003
RM-ES	Record Management - Evidentiary Support	October 01, 2008
RMF	Risk Management Framework	June 11, 2014
RMI	Remote Method Invocation	October 01, 2003
RMIR	OI&T Risk Management and Incident Response	December 08, 2009
RMIT	Resource Management Information Technology	November 30, 2007
RMON	Remote Monitor	June 08, 2005
RMP	Risk Management Plan	July 21, 2004
RMP	Release Management Process	April 23, 2014
RMRS	Regenstrief Medical Record System	Added prior to March 2003
RMS	Rights Management Services	November 02, 2009

RMS	Release Management Service	April 23, 2014
RMT	Release Management Team	April 23, 2014
RN	Registered Nurse	January 11, 2005
RNB	Reason Not Billable	February 22, 2010
RNE	Recreational Noise Exposure	March 01, 2010
RNFL	Retinal Nerve Fiber Layer	August 24, 2010
RNM	Radiology Nuclear Medicine	July 21, 2004
RO	Regional Office	Added prior to March 2003
RO&IC	Regional Office and Insurance Center	Added prior to March 2003
ROADS	Registry Operations And Data Standards	Added prior to March 2003
ROB	VA National Rules of Behavior	September 16, 2011
ROC	Rehearsal of Concept	May 07, 2014
ROC	Report of Contact	November 10, 2009
ROC	Readiness Operations Center	July 21, 2004
ROC	Regional Operations Center	January 21, 2016
ROES	Remote Order Entry System	Added prior to March 2003
ROI	Return On Investment	Added prior to March 2003
ROI	Release Of Information	Added prior to March 2003
ROJ	Regional Office of Jurisdiction	September 20, 2010
ROLAP	Relational On-Line Analytical Processing	July 21, 2004
ROM	Rough Order of Merit	June 16, 2003
ROM	Resource and Organizational Management	April 17, 2014
ROM	Rough Order of Magnitude	October 12, 2010
ROM	Range of motion	September 23, 2014
RON	Rest Over Night	March 15, 2010
RONA	Release of Names and Addresses	July 21, 2004
RO-OC	Regional Office-Outpatient Clinic	Added prior to March 2003
ROP	Reordering Points	May 19, 2015
ROQ	Reordering Quantities	May 19, 2015
ROQ	Review of Quality	July 21, 2004
RORC	Rehabilitation Outcomes Research Center	July 06, 2009
ROS	Report of Survey	April 09, 2009
ROS	Review of Systems	March 23, 2015
ROS	Results of Sale	August 11, 2015
ROVAS	Refusal of VA Services	December 28, 2011
RPC	Regional Processing Center	April 14, 2003
RPC	Remote Procedure Call	Added prior to March 2003
RPC	Radiation Policy Council	Added prior to March 2003
RPC Broker	Remote Procedure Call Broker	Added prior to March 2003
RPG	Rocket Propelled Grenade	March 08, 2007

RPIW	Rapid Process Improvement Workshop	April 17, 2014
RPL	Restricted Patient List	Added prior to March 2003
RPM	Resource Planning Model	Added prior to March 2003
RPM	Resource Planning and Management (Committee)	Added prior to March 2003
RPMS	Resource and Patient Management System	Added prior to March 2003
RPN	Risk Priority Number	December 14, 2016
RPO	Recovery Point Objective	July 21, 2004
RPO	Regional Processing Office	March 23, 2007
RQST	REQUEST	October 25, 2011
RR	Respiratory Rate	August 14, 2014
RR	Responsible Role	July 30, 2015
RR&D	Rehabilitation Research and Development	Added prior to March 2003
RRR	Regular rate rythm	August 14, 2014
RRS	Records Retrieval System	May 20, 2010
RRT	Registered Respiratory Therapist	December 16, 2011
RS	Rescheduled	October 22, 2015
RSA	Replacement Scheduling Application	June 09, 2008
RSA	Resource Scheduling Allocation	February 10, 2004
RSAT	Residential Substance Abuse Treatment	June 25, 2014
RSC	Revenue Source Code	April 15, 2010
RSC	Radiation Safety Committee	April 11, 2007
RSC	Regional Support Center	April 24, 2006
RSC	Resolution Support Center	December 15, 2016
RSD	Requirements Specification Document	May 24, 2011
RSD	REFLEX SYMPATHETIC DYSTROPHY	April 30, 2014
RSD	Roger Software Development	April 23, 2014
RSD	Report System Distribution	July 21, 2004
RSF	Rentable Square Footage	July 30, 2015
RSLSP	Retroactive Stop Loss Pay	September 27, 2010
RSNA	Radiological Society of North America	Added prior to March 2003
RSO	Radiation Safety Officer	March 15, 2004
RT	Reference Terminology	Added prior to March 2003
RT	related to	December 03, 2014
RT	Respiratory Therapist	August 04, 2014
RTC	Return To Clinic	August 26, 2004
RTCIS	Remote Telepathology Consultation and Imaging System	Added prior to March 2003
RTEP	Request for Task Execution Plan	January 21, 2016
RTF	Rich Text Format	June 08, 2005
RTLS	Real Time Location System	April 23, 2014
RTLS	Real-Time Location System	August 10, 2010
RTM	Requirement Traceability Matrix	February 18, 2010

RTM	Reference Terminology Model	Added prior to March 2003
RTM	Requirements traceability matrix	April 17, 2015
RTNPC	Return To Nurse Procedure Clinic	April 14, 2009
RTO	Recovery Time Objective	July 21, 2004
RTR	Ready-to-Rate	October 22, 2015
RTSUB	Rational Tools Service Request database name	June 02, 2006
RTT	OED Rational Tools Team	October 27, 2009
RUG	Resource Utilization Groups	Added prior to March 2003
RUM	Resource Usage Monitor	Added prior to March 2003
RUP	Rational Unified Process	July 21, 2004
RUQ	right upper quadrant of abdomen	August 04, 2014
RUQ	right upper quadrant	November 10, 2011
RUR	Revenue Utilization Review	August 11, 2015
RVEC	Regional Veterans Employment Coordinator	June 16, 2015
RVN	Republic of Vietnam	April 23, 2014
RVR	Rapid Ventricular Response	August 04, 2014
RVS	Relative Value Scale	Added prior to March 2003
RVSR	Rating Veterans Service Representative	May 27, 2008
RVU	Relative Value Unit	Added prior to March 2003
RVW	review	December 15, 2016
RX	Prescription	July 21, 2004
RXCOTS	Pharmacy Commercial Off the Shelf	June 30, 2003
S		top
S&D	Storage and Distribution	Added prior to March 2003
S&DC	Service and Distribution Center	Added prior to March 2003
S.O.B.	Shortness Of Breath	November 27, 2007
S/I	Suicide Ideation	October 31, 2007
S/S	Signs or Symptoms	October 10, 2006
SA	Security Architecture	January 21, 2016
SAA	State Approving Agency	April 23, 2014
SAAG	Serum albumin ascites gradient	April 23, 2014
SAAN	Supply Automation Advisory Network	Added prior to March 2003
SAB	Standards Advisory Board	Added prior to March 2003
SAC	Standards and Conventions	Added prior to March 2003
SAC	Special Agreement Check	January 03, 2011
SAC	Senate and Appropriations Committee	March 08, 2010
SACC	Standards & Conventions Committee	Added prior to March 2003
SAD	Software Architecture Document	July 26, 2004
SADR	Standard Ambulatory Data Record	May 27, 2003
SAE	Serious Adverse Event	December 15, 2008

SAEAF	Service Aware Enterprise Architecture Framework	April 20, 2009
SAGG	Statistical Analysis Global Growth	July 26, 2004
SAH	Special Adaptive Housing	March 23, 2015
SAIC	Science Applications International Corporation	Added prior to March 2003
SAIF	Service Aware Interoperability Framework	April 23, 2014
SAIL	Strategic Analytics for Improvement and Learning	April 23, 2014
SAIM	Supporting All Improvement Methodologies	April 21, 2016
SAM	Secured administrative message	March 23, 2015
SAM	Subsistence Allowance Module	April 17, 2014
SAM	Strategic Asset Management	October 31, 2007
SAMHSA	Substance Abuse and Mental Health Services Administration	January 25, 2008
SAML	Security Assertion Mark-up Language	February 18, 2010
SAN	Storage Area Network	Added prior to March 2003
SANVR	Salvation Army Northport Veterans Residence	January 03, 2007
SAO	Supervisory Administrative Officer	August 10, 2010
SAO	Senior Accountable Official	August 10, 2010
SAO	Service Area Organization	April 20, 2010
SAO	Service Area Office	January 21, 2016
SAP	Simplified Acquisition Procedures	May 13, 2010
SAPP	Servicer Appraisal Processing Program	October 04, 2010
SAQ	short arc quad	September 23, 2008
SAR	Staff Appraisal Reviewer	July 14, 2010
SARP	Substance Abuse Rehabilitation Program	Added prior to March 2003
SARRTP	Substance Abuse Residential Recovery Treatment Program	January 03, 2007
SARS	Severe Acute Respiratory Syndrome	January 23, 2008
SAS	Statement on Auditing Standards	February 18, 2010
SAS	Statistical Analysis System	July 26, 2004
SASE	Self Addressed Stamped Envelope	December 14, 2016
SAT	Special Assistance Team	Added prior to March 2003
SAT	Senior Assessment Team	May 11, 2006
SAT	Saturday	August 14, 2014
SAT	Simplified Acquisition Threshold	May 13, 2010
SATA	Serial Advanced Technology Attachment	February 02, 2006
SATCOM	Satellite Communications Unit/Terminal	June 06, 2006
SATP	Substance Abuse Treatment Program	November 30, 2009
SATRWG	Software Application Testing and Review Workgroup	October 12, 2010
SATT	Substance Abuse Treatment Team	January 25, 2006
SAVE	Signs Ask Validate Encourage	September 23, 2008
SAVES	Suicidal Alert Veterans Emergency System	April 04, 2011
SAW	School At Work	March 31, 2010

SB	Sinus Bradycardia	August 14, 2014
SB/SDB	Small Business/Small Disadvantaged Business	May 12, 2010
SB/SDB	Small Business/Small Disadvantaged Business	May 12, 2010
SBA	Small Business Administration	May 12, 2010
SBA	Small Business Administration	May 12, 2010
SBA	Standby Assistance	February 06, 2015
SBAR	Situation, Background, Assessment, Recommendation	June 01, 2010
SBC	Survivor Benefits Center	June 14, 2011
SBR	Suicide Behavior Report	January 21, 2016
SC	subcutaneous	August 04, 2014
SC	Service Connected	May 30, 2007
SCA	Security Control Assessment	April 27, 2009
SCA	Special Contribution Award	Added prior to March 2003
SCAMC	Symposium On Computer Applications In Medical Care	Added prior to March 2003
SCAMP	Security Configuration And Management Program	December 01, 2003
SCAMPI	Standard CMMI Appraisal Method for Process Improvement	March 27, 2007
SCAN-ECHO	Specialty Care Access Network-Extension for Community Healthcare Outcomes	May 19, 2015
SCAP	Security Content Automation Protocol	April 13, 2010
SCC	Scope Change Control	July 26, 2004
SCCM	System Center Configuration Manager	June 23, 2010
SCD	Spinal Cord Dysfunction Registry	Added prior to March 2003
SCD	Service Connected Disease	Added prior to March 2003
SCD	Service Computation Date	October 22, 2015
SCEM	Standards, Criterion, Evaluative Algorithms and Measuring Instruments	Added prior to March 2003
SCEP	Student Educational Employment Program	December 29, 2009
SCG	Senior Coordinating Group	May 07, 2014
SCGP	State Cemetery Grants Program	March 15, 2010
SCHCS	Small Composite Health Care System (DoD)	Added prior to March 2003
SCI	Spinal Cord Injury	Added prior to March 2003
SCI HC	Spinal Cord Injury Home Care Program	December 10, 2014
SCIDO	Spinal Cord Injury Disorder	May 05, 2010
SCIF	Secure Compartment Information Facility	Added prior to March 2003
SCIFD	Standardization, Compatibility, Interoperability and Fiscal Discipline	March 31, 2009
SCIP	Surgical Care Improvement Project	May 06, 2009
SCIP	Spinal Cord Injury Program	December 28, 2007
SCIP	Strategic Capital Investment Process	May 26, 2010
SCM	Supply Chain Management	April 10, 2014
SCM	Security Configuration and Management (Program)	November 26, 2003
SCM	Source Code Management	August 11, 2015

SCNR	site clear nonred	December 14, 2016
SCORM	Sharable Content Object Reference Model	July 28, 2008
SCQC	Software Code Quality Checking	March 23, 2015
SCR	Serum Creatinine	May 19, 2015
SCRA	Servicemember Identification for Servicemember Civil Relief Act	April 23, 2014
SCRIPT	Suicidal Caller Response Incident Protocol Training	April 23, 2014
SCS	Subscription Control Service	July 26, 2004
SCSI	Small Computer System Interface	February 02, 2006
SCUNA	Service-Connected Unauthorized	August 12, 2009
SCVTS	Switch Compressed Video Transmission Service	Added prior to March 2003
SD&D	Systems Design and Development	July 26, 2004
SD&E	Service Delivery and Engineering	December 01, 2010
SD&E PAO	Service Delivery and Engineering (SD&E) Program Administration Office (PAO)	February 07, 2011
SDC	Strategic Directions Committee	September 22, 2011
SDC	Same Day Clinic	April 23, 2014
SDC	System Development Center	Added prior to March 2003
SDD	System Design Document	April 18, 2014
SDD	Software Design and Development	July 26, 2004
SDE	Service Delivery and Engineering	December 16, 2011
SDK	Software Development Kit	December 14, 2016
SDLC	System Development Life Cycle	August 05, 2004
SDM	Service Desk Manager	April 12, 2014
SDM	Service Desk Manager	May 01, 2014
SDO	Standards Development Organization	July 26, 2004
SDP	Supervised Direct Pay	April 17, 2015
SDS	Standard Data Service	July 26, 2004
SDS	System Development Support	March 01, 2007
SDV	Self-Directed Violence	June 16, 2015
SDVCS	Self-Directed Violence Classification System	June 16, 2015
S-DVI	Service-Disabled Veterans Insurance	May 27, 2016
SDVOSB	Service Disabled Veteran-Owned Small Business	January 23, 2007
SE	Supported Employment	July 17, 2008
SE	Supported Employment	August 21, 2008
SE	Side Effects	June 16, 2015
SE&I	Software Engineering & Integration	April 11, 2007
SEC	Screening and Evaluation Committee	Added prior to March 2003
SECVA	Secretary	January 29, 2009
SEDR	Systems Engineering and Design Review	December 16, 2011
SEER	Surveillance, Epidemiology, and End Results Reporting	February 06, 2015

SEES	Survey Evaluation Exam System	October 20, 2011
SEI	Software Engineering and Integration	March 23, 2007
SEI	Self Entered Information	July 10, 2006
SEP	Systems Engineering Plan	April 30, 2014
SEP	Stakeholder Enterprise Platform	October 22, 2015
SEPG	Software Engineering Process Group	Added prior to March 2003
SEPS	Space & Equipment Planning System	May 26, 2010
SERP	Systematic External Review Program	Added prior to March 2003
SES	Senior Executive Review Program	Added prior to March 2003
SES	Senior Executive Service	May 07, 2014
SEWP	Solutions for Enterprise-Wide Procurement	July 21, 2009
SF	Standard form	August 04, 2014
SF	Standard Form	July 26, 2004
SFA	Strategic Focus Area	April 01, 2008
SFDI	Space and Functional Deficiency Identification System	Added prior to March 2003
SFFX	Shared Folder and File Exchange	June 25, 2014
SFT	Store Forward Technology	September 23, 2014
SFTP	Secure File Transfer Protocol	January 21, 2016
SG	Surgeon General	May 07, 2014
SGL	Standard General Ledger	June 16, 2015
SGLI	Servicemembers Group Life Insurance	April 03, 2014
SGLI	Servicemen's Group Life Insurance	Added prior to March 2003
SGML	Standard Generalized Markup Language	Added prior to March 2003
SHA	Separation Health Assessment	July 30, 2015
SHAD	Shipboard Hazard and Defense	Added prior to March 2003
SHCGP	State Home Construction Grant Program	March 17, 2009
SHEP	Survey of Healthcare Experiences of Patients	September 20, 2005
SHG	Strategic Healthcare Group	Added prior to March 2003
SHRAC	Strategic Human Resource Advisory Committee	April 23, 2014
SHS	Society for Health Systems	Added prior to March 2003
SHS	Secure Hash Standard	June 21, 2010
SHT	Shift Handoff Tool	August 12, 2009
SI	System Implementation	July 26, 2004
SI/HI	Suicidal Ideation/Homicidal Ideation	March 09, 2009
SI/SI	Severely Injured/Seriously Ill	July 28, 2008
SIA	System Interconnection Agreement	Added prior to March 2003
SIB	Self Injurious Behavior	November 30, 2009
SIC	Security Investigations Center	May 01, 2014
SIC	Security Investigation Center	April 18, 2014
SIC	System Integration Center	July 26, 2004
SICU	Surgical Intensive Care Unit	March 12, 2009

SIDR	Standard Inpatient Data Record	April 11, 2007
SIEM	Security Information and Event Management	April 21, 2016
SIG	Signa (Latin)	November 22, 2004
SIG	Special Interest Group	Added prior to March 2003
SIIT	Surgical Infrastructure Inventory Tool	April 17, 2015
SIM	Stakeholder Information Management	April 18, 2014
SIM	Strategic Investment Management	April 18, 2014
SIO	System Integration Office	April 23, 2014
SIP	Session Initiation Protocol	April 23, 2014
SIP	Supplier Idea Portal	October 25, 2011
SIP	Strategic Implementation Plan	April 23, 2014
SIPRNET	Secret Internet Protocol Router Network	April 18, 2014
SIPU	Specialized Intensive PTSD Unit	March 07, 2008
SIR	Systematic Internal Review	Added prior to March 2003
SISP	Strategic Information Systems Plan	Added prior to March 2003
SIT	Systems Integration Test	August 14, 2007
SIUG	Special Interest Users Group	Added prior to March 2003
SIWG	Scheduling Interoperability Workgroup	June 03, 2004
SKIPPES	Skills, Knowledge, Insurance Procedures and Practices Embedded in Systems	July 26, 2004
SKU	Stock Keeping Unit	July 26, 2004
SL	Saline Lock	August 14, 2014
SL	Sick leave	March 02, 2009
SL	Service Line	December 15, 2016
SLA	Service Level Agreement	July 15, 2004
SLAB	Service Level Approval Board	April 23, 2014
SLAM	Service Level Agreement Modification	April 23, 2014
SLAM	Service Level Agreement Modification	April 23, 2014
SLAP	Service Level Approval Process	April 23, 2014
SLC	Special Law Code	October 27, 2009
SLIMS	Summary List Management Service	Added prior to March 2003
SLIP	Serial Line Interface Protocol	Added prior to March 2003
SLIP	Shortest Life Into Production	October 01, 2008
SLMB	Service Level Management Board	April 15, 2010
SLP	Station Level Project	June 04, 2009
SLP	Speech-Language Pathologist	May 23, 2006
SLR	Straight Leg Raise	September 23, 2008
SLR	Service Level Requirement	January 20, 2011
SLRP	Student Loan Repayment Program	May 07, 2014
SLT	Service Level Target	January 20, 2011

SM	Service Members	March 16, 2009
SM	Secure Message	February 06, 2015
SMA	Shared Medical Appointment	May 03, 2011
SMAG	Special Medical Advisory Group	Added prior to March 2003
SMART	Site Monitoring, Auditing and Resource Team (VA Cooperative Studies Program)	August 10, 2010
SMART	SMART	July 18, 2014
SMART	Security Management and Reporting Tool	March 25, 2009
SMART	Science, Mathematics, and Research for Transformation	April 03, 2006
SMBG	Self-Monitored Blood Glucose	January 04, 2012
SMC	Strategic Management Council	Added prior to March 2003
SMC	Special Monthly Compensation	November 18, 2015
SMDS	Switched Multimegabit Data Services	July 26, 2004
SME	Subject Matter Expert	Added prior to March 2003
SMG	Strategic Management Group	Added prior to March 2003
SMI	Serious Mental Illness	November 17, 2008
SMIB	Supplemental medical Insurance Benefit	September 04, 2015
SMIME	Secure/Multipurpose Internet Mail Extensions	July 26, 2004
SMI-S	Storage Management Initiative Specification	June 08, 2005
SMITREC	Serious Mental Illness Research and Evaluation Center	November 17, 2008
SMMR2	Six Month Maintenance Release 2	Added prior to March 2003
SMOCTA	Service Members Occupational Conversion and Training Act of 1992	December 08, 2009
SMP	Strategic Management Process	Added prior to March 2003
SMP	Symmetric Multiprocessing	July 26, 2004
SMR	Standardized Mortality Ratio	May 24, 2011
SMRTS	Service Medical Records Tracking System	July 26, 2004
SMS	Software Management Server	July 26, 2004
SMS	Shared Medical Systems (one of the largest hospital software vendors)	Added prior to March 2003
SMS	System Management Software	Added prior to March 2003
SMTP	Simple Mail Transfer Protocol	Added prior to March 2003
SNA	Systems Network Architecture	July 26, 2004
SNAC	Systems and Network Attack Center	June 11, 2014
SNAP	Supplemental Nutrition Assistance Program	April 21, 2016
SNF	Skilled Nursing Facility	June 10, 2010
SNI	Standardized Numeric Identifier	April 23, 2014
SNMP	Simple Network Management Protocol	July 26, 2004
SNOMED	Systematized Nomenclature of Medicine	Added prior to March 2003
SNOMED CT	Systemized Nomenclature of Medicine Clinical Terms	March 31, 2003
SNT	STUDENT NURSE TECHNICIAN	December 14, 2016
SNTP	Soft Nontender to palpation	May 19, 2015

SNV	SKILLED NURSING VISIT	November 18, 2015
SOA	Service Oriented Architecture	June 07, 2004
SOA	System-Oriented Architecture	June 06, 2014
SOAP	Subjective, Objective, Assessment, and Plan	Added prior to March 2003
SOAP	Simple Object Access Protocol	October 01, 2003
SOAR	Strategic Objective annual review	April 17, 2014
SOARS	System-wide Ongoing Assessment and Review Strategy	December 15, 2003
SOB	Shortness of Breath	March 13, 2008
SOC	Senior Oversight Committee	May 21, 2007
SOC	Security Operations Center	Added prior to March 2003
SOC	Statement of the Case	July 26, 2004
SOC	Satellite Outpatient Clinic	July 21, 2004
SOE	Service Oriented Enterprise	April 18, 2014
SOE	Survey of Enrollees	March 26, 2009
SOE	Service Oriented Enterprise	May 01, 2014
SOG	Standard Operating Guideline	January 23, 2007
SOI	Service Oriented Infrastructure	April 18, 2014
SOI	Security Office Identifier	March 23, 2015
SOJ	System of Jurisdiction	August 16, 2011
SON	Submitting Office Number	March 23, 2015
SONP	Satellite Overlay Network Project	May 12, 2003
SOO	Statement of Objective	Added prior to March 2003
SOO	Station Of Origin	April 03, 2015
SOP	Standard Operating Procedure	May 10, 2006
SOPC	Satellite Outpatient Clinic	January 23, 2007
SOR	System of Record	Added prior to March 2003
SORN	System of Records Notice	March 01, 2010
SOS	Scrum of scrums	December 15, 2016
SOTA	State of the Art Conferences	June 08, 2010
SOW	Statement of Work	Added prior to March 2003
SP	Standards of Profile	July 26, 2004
SP	ScriptPro	May 19, 2015
SP	Special Publication	October 06, 2011
SP	spouse	December 15, 2016
SPAN	Suicide Prevention Application Network	April 15, 2014
SPAR	Sensitive Patient Access Report	February 15, 2011
SPARQ	SPECIALTY PRODUCTIVITY-ACCESS REPORT and QUADRANT TOOL DATA	October 22, 2015
SPARQ	Specialty Productivity - Access Report and Quadrant Tool	October 29, 2015
SPAWARS	Space and Naval Warfare Systems	February 25, 2008

SPC	Suicide Prevention Coordinator	October 10, 2007
SPCM	Suicide Prevention Case Manager	January 21, 2016
SPD	Sterile Processing Department	August 08, 2011
SPD	Supply, Processing, and Distribution	April 23, 2014
SPD	Supply Processing and Distribution	July 26, 2004
SPDAT	Service Prioritization Decision Assistance Tool	September 04, 2015
SPDMP	State Prescription Drug Monitoring Program	May 19, 2015
SPES	Single Photon Emission Scanning	Added prior to March 2003
SPHM	Safe Patient Handling and Movement	February 22, 2011
SPI	Spend Plan Identification	February 09, 2011
SPI	Spend Plan Item	June 11, 2014
SPI	Sensitive Personal Information	July 18, 2014
SPI	Schedule Performance Index	July 22, 2003
SPMI	Serious and Persistent Mental Illness	October 31, 2011
SPML	Service Provisioning Markup Language	September 23, 2014
SPNEGO	Simple and Protected Negotiation Mechanism	July 29, 2009
SPOC	Service Point of Contact	April 11, 2007
SPP	IT Enterprise Strategy, Policy, Plans and Programs	September 01, 2009
SPP	Scalable Parallel Processing	July 26, 2004
SPS	Strategic Planning Service	March 26, 2009
SPS	Sterile Processing Services	February 14, 2012
SPSS	Statistical Package for the Social Sciences	April 17, 2014
SPV	Supervision	October 30, 2006
SQ	subquetaneous	August 14, 2014
SQA	Software Quality Assurance	July 26, 2004
SQA	Safety Quality Assurance	February 25, 2008
SQAS	Systems Quality Assurance Service	April 07, 2009
SQC	Statistical Quality Control	July 26, 2004
SQL	Structured Query Language	December 07, 2004
SQN	Surgical Quality Nurse	December 14, 2016
SQWM	Surgical Quality Workflow Manager	April 05, 2010
SR	Systems Redesign	December 29, 2011
SR	Sinus rythm	August 14, 2014
SR	Service Request	June 16, 2003
SRA	State Regulation Agencies	July 26, 2004
SRC	Systems Resources Corporation	Added prior to March 2003
SRM	Service Reference Model	October 29, 2003
SRO	Single Room Occupancy	August 12, 2010
SRR	System Requirements Review	Added prior to March 2003
SRS	Software Requirements Specification	Added prior to March 2003
SRSBS	Subcommittee on Research Safety, Biosafety and Security	December 27, 2010

SRT	Special Response Team	June 06, 2006
SRT	System Review Team	Added prior to March 2003
SS	sliding scale	May 19, 2015
SSA	Social Security Administration	July 26, 2004
SSAA	System Security Authorization Agreement	Added prior to March 2003
SSAC	Source Selection Advisory Council	May 12, 2010
SSAC	Source Selection Advisory Council	May 12, 2010
SSB	Special Separation Benefit	April 18, 2014
SSB	Special Separation Benefit	April 23, 2014
SSC	Support Services Centers	Added prior to March 2003
SSC	Surviving sepsis campaign	September 23, 2014
SSD	Service Support Division	April 15, 2014
SSEB	SOURCE SELECTION EVALUATION BOARD	September 04, 2015
SSH	Secure Shell	October 21, 2014
SSI S	SQL Server Integration Services	November 30, 2009
SSL	Secure Socket Layer	Added prior to March 2003
SSM	Software Service Manager	Added prior to March 2003
SSN	Social Security Number	Added prior to March 2003
SSO	Single Sign-On	June 08, 2005
SSOC	Supplemental Statement of the Case	July 26, 2004
SSO-CM	Single Sign-On and Context Management	April 23, 2014
SSP	System Security Plan	April 07, 2011
SSS	SICK SINUS SYNDROME	October 22, 2015
SSVF	Supportive Services for Veterans Families	July 06, 2010
ST	Speech therapist	April 23, 2014
ST	Sore throat or Sinus Tachycardia	August 14, 2014
ST	Sinus Tachycardia	August 14, 2014
STAIR	Sites of Temporarily Augmented Ionizing Radiation	Added prior to March 2003
STAP	Sustainment Transition Acceptance Plan	December 08, 2016
STAR	Statistical and Technical Accuracy Report	July 26, 2004
STAR	Servicemember Transitional Amputation Rehabilitation program	November 02, 2011
STAT	Supported Treadmill Ambulation Training	Added prior to March 2003
STC	Service Transition Charter	January 20, 2011
STC	Sunshine Training Center	January 06, 2009
STD	Standard	May 13, 2010
STDP	System To Drive Performance	January 10, 2011
STEMI	ST-elevation myocardial infarction	April 21, 2016
STEP	Student Temporary Employment Program	November 17, 2011
STEP	Secure Technology Evaluation Project	Added prior to March 2003
STEPPS	Strategies and Tools to Enhance Performance and Patient Safety	April 11, 2007

STI	Sexually Transmitted infection	August 04, 2014
STICC	Seamless Transition Integrated Care Clinic	July 30, 2015
STIG	Security Technical Implementation Guides	June 11, 2014
STM	Short Term Model	July 26, 2004
STO	Seamless Transition Office	June 30, 2005
STP	Software Test Plan	July 29, 2004
STP	Stress Treatment Program	June 25, 2014
STR	Software Test Report	July 29, 2004
STR	Service Treatment Record	November 02, 2011
STR	Service Training Record	March 08, 2010
STRS	Service Treatment Records	April 23, 2014
STS	Soft Tissue Sarcoma	Added prior to March 2003
STS	Standards & Terminology Services	July 10, 2006
STVHCS	South Texas Veterans Health Care System	March 15, 2004
SUD	Substance Abuse Disorder	October 22, 2008
SUD	Substance Use Disorders	April 20, 2009
SUDEP	Substance Use &Dependence Education Program	April 23, 2014
SUDEP	Sudden Unexpected Death in Epilepsy	December 14, 2016
SUDS	Substance Use Disorder Service	January 21, 2016
SUDTP	Substance Use Disorders Treatment Program	April 23, 2014
SUN	Sunday	August 14, 2014
SV	Systems View	April 23, 2014
SV	Service Voucher	September 27, 2010
SV	Systems Viewpoint	April 23, 2014
SV	Schedule Variance	July 22, 2003
SVAC	Senate Veterans Affairs Committee	Added prior to March 2003
SVH	State Veterans Homes	Added prior to March 2003
SVH CAP	State Veterans Home Corrective Action Plan	March 17, 2009
SVR	Sustained Virologic Response	April 30, 2014
SVSR	Senior Veteran Service Representatives	February 04, 2010
SVT	Supraventricular Tachycardia	August 04, 2014
SW	Social Worker	June 10, 2010
SWARS	Social Work Automated Reporting System	Added prior to March 2003
SWAT	SWift Action and Triage	June 16, 2015
SWOT	Strengths, Weaknesses, Opportunities, and Threats	May 05, 2010
SWRI	Southwest Research Institute	Added prior to March 2003
SWS	Social Work Service	June 10, 2010
SX OR SX	Symptom	August 04, 2014
T		top
T	Temperature	August 14, 2014

T	Temperature	October 22, 2015
T&A	Time & Attendance	Added prior to March 2003
T&C	Terms and Conditions	May 13, 2010
T&E	Test and Evaluation	Added prior to March 2003
T&L	Time & Leave	Added prior to March 2003
T&M	Time and Materials	July 30, 2015
T2P2	Theater Telemedicine Prototype Project	Added prior to March 2003
T4	Transformation Twenty-One Total Technology	September 23, 2014
TA	Technology Assessment	Added prior to March 2003
TAC	Technology Assessment Committee	Added prior to March 2003
TAC	Test and Certification (OED ProPath)	February 01, 2010
TAC	Technology Acquisition Center	October 05, 2009
TAFMS	Total active federal military service date	April 23, 2014
TAG	Technical Advisory Group	Added prior to March 2003
TAMC	Tripler Army Medical Center	Added prior to March 2003
TAP	Transition Assistance Program	Added prior to March 2003
TAR	Technical Agreements Repository	Added prior to March 2003
TAR	Test Analysis Report	July 26, 2004
TAR	Technical Analysis Review	July 27, 2009
TAR-TAS	Technical Analysis Review - Technical Analysis Summary	March 08, 2011
TAS	The Appraisal System	July 14, 2010
TAS	Treasury Account Symbol	September 20, 2010
TAS	Technical Analysis Summary	July 27, 2009
TAT	TURN AROUND TIME	April 14, 2011
TATO	Temporary Authority to Operate	June 11, 2014
TAVR	transcatheter aortic valve replacement	October 22, 2015
TB	Tuberculosis	August 04, 2014
TBA	To Be Announced	July 26, 2004
TBD	To Be Determined	July 26, 2004
TBE	The Benchmarking Exchange	March 08, 2007
TBI	Traumatic Brain Injury	Added prior to March 2003
TBO	Telecommunications Business Operations	December 15, 2016
TC	Training Coordinator	July 26, 2004
TCCB	Technical Change Control Board	December 14, 2005
TCDB	Turn, Cough, Deep Breath	March 13, 2008
TCF	Technical Career Field	April 11, 2007
TCHP	Twin Cities Health Professionals (Education Consortium)	April 21, 2016
TCM	Transition & Care Management	January 21, 2016
TCMP	Technology Change Management Plan	Added prior to March 2003
TCP	Telephone Care Program	December 15, 2016
TCP/IP	Transmission Control Protocol/Internet Protocol	Added prior to March 2003

TCPR	Transportable Computer-based Patient Record	Added prior to March 2003
TCSC	Telecommunications Customer Service Council (formerly TOB)	Added prior to March 2003
TCT	telephone call to	April 15, 2014
TCT	telehealth clinical technician	December 16, 2011
TCU	Transitional Care Unit	April 17, 2014
TD	Tetnus Diptheria, as in immunization	August 04, 2014
TDA	Transfer of Disbursing Authority	Added prior to March 2003
TDA	Temporary Duty Assignment	December 15, 2016
TDE	Transparent Data Encryption	June 16, 2015
TDE	Terminology Development Environment	Added prior to March 2003
TDIP	Total Disability Income Provision	March 08, 2010
TDIU	Totally Disabled based on Individual Unemployability	August 17, 2010
TDP	Testing Designated Positions	July 30, 2015
TDRL	Temporary Disability Retired List	April 10, 2014
TDS	Terminology Deployment Server	July 10, 2006
TEEI	Office of Transition, Employment and Economic Impact	December 15, 2016
TEFSC	Toxic Embedded Fragmet Surveillance Center	October 02, 2007
TEMP	Temporary	August 14, 2014
TEMP	Temperature	August 14, 2014
TEMPO	Training Education Management Program Office	May 08, 2003
TEP	Training Event Package	April 23, 2014
TERA	Temporary Early Retirement Act	April 17, 2014
TEVAS	Technical Excellence Value Added Service	August 29, 2007
TF	Treating Facility	Added prior to March 2003
TF	timely filing	December 15, 2016
TFT	thyroid function tests	August 04, 2014
TFTP	Trivial File Transfer Protocol	July 26, 2004
TG	triglycerides	May 19, 2015
TH	Transaction History	April 20, 2010
THA	Telemental Health Assistant	December 03, 2014
THURS	Thursday	August 14, 2014
TIAG	The Informatics Applications Group	September 05, 2011
TIBOD	Technical Integration Board of Directors	Added prior to March 2003
TIC	Trusted Internet Connection	August 17, 2011
TICC	Transformation Initiative Collaboration Cell	May 07, 2014
TICC	Traumatic Brain Injury	May 07, 2014
TID	Three times daily	August 14, 2014
TIDES	Translating Initiatives for Depression into Effective Solutions	June 19, 2007
TIGR Team	Technology, Innovation, and Government Reform Team	July 08, 2009
TIM	Total Inventory Management	October 01, 2008

TIMPO	Tri-Service Infrastructure Management Program Office	Added prior to March 2003
TIMS	The Image Management System	July 26, 2004
TIN	Tax Identification Number	April 12, 2011
TINA	Truth in Negotiations Act	May 13, 2010
TINQ	Treasury Inquiry	April 23, 2014
TIP	Technology Innovation Program	April 23, 2014
TIP	Telecommunications Infrastructure Project	Added prior to March 2003
TIP	Transformation Initiatives and Pilots	December 14, 2016
TIPO	Technology Innovation Program Office	April 23, 2014
TIU	Text Integration Utility	Added prior to March 2003
TIWG	Technical Integration Working Group	Added prior to March 2003
TJC	The Joint Commission (formerly JCAHO)	May 24, 2010
TJEB	Transformation Joint Execution Board	April 30, 2014
TKO	To Keep Open	April 21, 2016
TKR	Total Knee Replacement	December 08, 2016
TL	Training Letter	December 14, 2016
TLCP	Telephone Liaison Care Program	May 03, 2011
TLS	Tumor Lysis Syndrome	February 07, 2011
TLS	Transport Layer Security	September 12, 2007
TLS	Transitional Living Services	April 17, 2014
TM	Technology Management	April 23, 2014
TMA	TRICARE Management Activity	Added prior to March 2003
TMC	Training Management Committee	Added prior to March 2003
TMC	Travel Management Center	Added prior to March 2003
TMDQ	Terminology Model Data Quality	June 30, 2003
TMDS	Theater Medical Data Store (DoD acronym)	October 10, 2007
TMED	Telemedicine	Added prior to March 2003
TMH	Telemental Health	September 23, 2014
TMII	Theater Medical Information Infrastructure	Added prior to March 2003
TMIP	Theater Medical Information Program	Added prior to March 2003
TMJ	Temporomandibular joint	April 04, 2011
TMO	Telework Managing Officer	February 06, 2015
TMOP	TRICARE Mail Order Pharmacy	April 27, 2010
TMP	Telecommunication Modernization Project	Added prior to March 2003
TMS	Talent Management System	April 14, 2011
TMS	Telepresence Management Suite	October 29, 2015
TMT	Transition Management Team	March 31, 2009
TO	Task Order	February 22, 2010
TOB	Telecommunications Oversight Board (now TCSC as of 7/99)	Added prior to March 2003
TOC	Transfer of Care	April 03, 2014
TOD	Tour of Duty	December 15, 2008

TOP	Treasury Offset Program	November 10, 2011
TORB	Telephone order read back	April 21, 2016
TP	Technical Proposal	May 13, 2010
TPA	Third Party Administrator	October 30, 2014
TPA	Transition Patient Advocate	December 03, 2007
TPA	Transferring Patient Advocate	April 11, 2007
TPA	Trading Partner Agreement(s)	April 27, 2004
TPI	Two Person Integrity	April 11, 2007
TPJI	Third Party Joint Inquiry	February 20, 2007
TPN	Total Parenteral Nutrition	February 25, 2008
TPR	Tempature, Pulse, Respiration	July 30, 2015
TPS	Team Puget Sound	June 03, 2005
TPSS	Training Performance Support System	July 26, 2004
TPWG	Testing Process Work Group	April 12, 2006
TQCVL	Trainee Qualifications and Credentials Verification Letter	July 03, 2007
TQM	Total Quailty Management	May 13, 2010
TQM	Total Quality Management	Added prior to March 2003
TQS	Terminology Query Services	July 26, 2004
TQT	Tourniquet	November 06, 2007
TR	Transitional Residence	August 21, 2008
TRA	To run at, as in speed of medication	August 14, 2014
TRAAC	Telehealth and Rural Access Advisory Committee	November 30, 2009
TRAC2ES	TRANSCOM Regulating and Command Control Evacuation System	Added prior to March 2003
TRACS	Total Record Archive Communication Systems	Added prior to March 2003
TRAIT	Transparency, Accountability, Innovation, and Teamwork	February 02, 2016
TRAP	Telehealth and Rural Access Program	November 30, 2009
TRFC	Treasury Regional Financial Center	July 14, 2010
TRI	Teleretinal Imaging	December 15, 2016
TRIMIS	Tri-Services Medical Information System (DoD)	Added prior to March 2003
TRM	Technical Reference Model	July 26, 2004
TRM/SP	Technical Reference Model and Standards Profile	Added prior to March 2003
TRO	to run over, as in intravenous fluids to run over 1 hour	August 14, 2014
TRR	Test Readiness Review	April 17, 2014
TRS	TRICARE Reserve Select	April 11, 2007
TRUS	TRANSRECTAL ULTRASOUND	December 15, 2016
TSA	Telehealth Service Agreement	September 23, 2014
TSA	Test Site Agreement	August 31, 2006
TSI	Transition Systems, Inc.	Added prior to March 2003
TSO	Telecommunications Support Office	Added prior to March 2003
TSO	Technical Support Office	March 23, 2005

TSP	Thrift Savings Plan	August 06, 2007
TSP	Tuition Support Program	April 02, 2008
TSPR	Technical Services Project Repository	Added prior to March 2003
TSS	Telecommunications Support Service	Added prior to March 2003
TSS	Telehealth Scheduling System	September 23, 2014
TSS	Total Supply Support	April 30, 2014
TST	Touch Screen Technology	May 07, 2014
TT&E	Technical Training and Evaluation	April 17, 2014
TTB	Tub Transfer Bench	September 23, 2008
TTD	Technology Transfer Division	Added prior to March 2003
TTE	transthoracic Echocardiogram	December 10, 2014
TTF	Transformation Task Force	April 20, 2009
TTO	Temporary Transfer	September 04, 2015
TTSI	Technology Tools Solution Identification	May 20, 2010
TTWB	Toe-Touch Weight Bearing	January 21, 2016
TUES	Tuesday	August 14, 2014
TVC	TEXAS VETERANS COMMISSION	March 23, 2015
TVCS	Trend Virus Control Software	Added prior to March 2003
TVO	telephone verbal order	January 21, 2016
TW	Transitional Work	March 01, 2011
TWD	Total Weekly Dose	April 03, 2014
TWE	Transitional Work Experience	December 15, 2016
TWIG	Technical Working Integration Group	April 30, 2014
TX OR TX	Treatment	August 04, 2014
U		top
U.S.C.	United States Code	May 13, 2010
U/O OR UO	Urinary output	August 14, 2014
U3P	Unauthorized Third Party	December 15, 2016
UA	urinalysis	August 04, 2014
UA OR U/A	urinalysis	August 14, 2014
UAT	User Acceptance Testing	April 27, 2004
UBS	Universal Billing System	Added prior to March 2003
UC	Underpinning Contract	January 20, 2011
UCC	Uniform Commercial Code	May 13, 2010
UCC	Urgent Care Center	January 06, 2010
UCI	User Class Identifier	February 18, 2010
UCS	Universal Character Set	September 22, 2011
UCUM	Unified Codes for Units of Measure	November 27, 2007
UD	Unit Dose	Added prior to March 2003
UDDI	Universal Description, Discovery and Integration	June 08, 2005

UDI	Unique Device Identifier	April 23, 2014
UDI	USAGE DEMAND ITEM	December 15, 2016
UDO	Undelivered Orders	March 31, 2010
UDS	Urinary Drug Screen	April 17, 2014
UDS	Urodynamics Study	June 16, 2015
UE	Upper extremity	September 23, 2014
UFH	Unfractionated Heparin	January 21, 2016
UFR	Unfunded Requirement	April 17, 2014
UFR	Unfunded Request	April 23, 2014
UFR	Unfunded Request	April 23, 2014
UFT	User Functional Test	June 14, 2011
UGI	Upper Gastrointestinal	May 01, 2014
UHCg	Urine pregnancy test	August 14, 2014
UHF	Ultra High Frequency	December 15, 2005
UHID	Universal Healthcare Identifier	February 09, 2009
UI	User Interface	March 23, 2007
UI	Universal Interface	Added prior to March 2003
UM	Utilization Management	April 30, 2014
UMC	Universal Master Catalog	April 03, 2014
UMDNS	Universal Medical Device Nomenclature System	October 21, 2003
UME	Unreimbursed Medical Expenses	April 10, 2014
UML	Unified Modeling Language	October 01, 2003
UMLS	Unified Medical Language System	Added prior to March 2003
UOR	Uniform Offense Report	May 07, 2014
UPC	Unit Production Cost	May 13, 2010
UPIN	Unique Physician Identification Number	March 31, 2010
UPM	Universal Project Milestone	April 23, 2014
UPN	Universal Product Number	Added prior to March 2003
UPN	Universal Principal Name	December 27, 2006
UPS	Uninterruptible Power Supply	June 08, 2005
UPT	Urine Pregnancy Test	April 15, 2014
UR	Utilization Review	September 20, 2010
URAC	Utilization Review Accreditation Commission	July 16, 2003
URI	Upper Respiratory Infection	August 04, 2014
URI	Unique Record Identifier	February 18, 2010
URL	Uniform Resource Locator	July 26, 2004
URL	Universal Record Location	Added prior to March 2003
US	United States	July 26, 2004
USA	UNITED STATES ARMY	November 18, 2015
USAF	United States Air Force	May 13, 2010
USB	Universal Serial Bus	March 09, 2009

USB	Under Secretary for Benefits	December 15, 2008
USC	United States Code	July 21, 2004
USCG	United States Coast Guard	April 23, 2014
USD(P&R)	Under Secretary for Defense for Personnel and Readiness	Added prior to March 2003
USDA	United States Department of Agriculture	Added prior to March 2003
USG	United States Government	July 26, 2004
USGLI	U.S. Government Life Insurance	July 14, 2010
USH	Under Secretary for Health	July 26, 2004
USHIK	United States Health Information Knowledgebase	October 01, 2008
USMC	UNITED STATES MARINE CORPS	November 18, 2015
USMS	U.S. Marshal Service	June 06, 2006
USN	United States Navy	May 13, 2010
USOC	U.S. Olympic Committee	October 21, 2011
USPHS	U.S. Public Health Service	Added prior to March 2003
USPS	United States Postal Service	April 21, 2016
USPTF	United States Preventative Services Task Force	Added prior to March 2003
USPTO	United States Patent and Trademark Office	February 09, 2009
USUHS	Uniformed Services University of the Health Sciences	March 24, 2003
UTC	Unable to Contact	November 30, 2009
UTD	up to date	April 23, 2014
UTF	UCS Transformation Format	September 22, 2011
UTI	Urinary Tract Infection	September 05, 2011
UTSWMC	University of Texas South West Medical Center	May 04, 2009
UTT	Unable to Test	December 15, 2016
UX	User eXperience	April 23, 2014
V		top
V.	Versus	May 13, 2010
V/C	verbal cues	April 23, 2014
V/CHIO	Veteran/Consumer Health Informatics Office	April 10, 2014
V/H	Visual Hallucinations	October 31, 2007
VA	Department of Veterans Affairs (never use DVA)	Added prior to March 2003
VA STVHCS	VA South Texas Veterans Health Care System	Added prior to March 2003
VAAA	Veterans Affairs Acquisition Academy	December 07, 2010
VAAFI	Veterans Affairs Authentication Federation Infrastructure	April 10, 2014
VAAFI	VA Authentication Federation Infrastructure	April 23, 2014
VAAR	VA Acquisition Regulations	Added prior to March 2003
VAAS	VA Assignment System	Added prior to March 2003
VAAS	VA Automated Appraisal Assignment System	May 07, 2014
VAB	VHA As-Is Baseline	August 22, 2006
VAC	Veterans Assistance Center	Added prior to March 2003

VAC	Variance At Completion	July 22, 2003
VACAA	Veterans Access Choice and Accountability Act of 2014	September 23, 2014
VACERT	Veterans Affairs Certification	July 26, 2004
VACHCS	VA Connecticut Health Care System	Added prior to March 2003
VACIB	VA Capital Investment Board	Added prior to March 2003
VACIRC	Veterans Affairs Central Incident Response Capability	July 27, 2004
VA-CIRC	Veterans Affairs Central Incident Response Capability	Added prior to March 2003
VACM	Veterans Affairs Capabilities Model	April 17, 2014
VACO	VA Central Office	Added prior to March 2003
VACOLS	Veterans Appeals Control and Location System	Added prior to March 2003
VADIR	VA/DoD Identity Repository	June 02, 2010
VADS	Veterans Assistance Discharge System	July 27, 2004
VAE	VistA Access Enhancements (VAE)	December 15, 2016
VAE	Veterans Affairs Examination	January 21, 2016
VAEAS	VA Enterprise Archiving Solution	May 10, 2010
VAEB	VA Executive Board	June 06, 2014
VA-ETP	Veterans Affairs Enterprise Transition Plan	August 12, 2009
VAF	Veterans Affairs Form	July 27, 2004
VAGFE	VA-owned Government Furnished Equipment	June 12, 2006
VAHCPOA	VA Health Care Power of Attorney	April 23, 2014
VAHCS	Department of Veterans Affairs Health Care System	February 11, 2009
VAI	Veterans Assistance Inquiry	July 27, 2004
VAIIP	VA Innovation Intern Program	May 01, 2014
VAIOC	VA Integrated Operations Center	January 20, 2011
VAIQ	VA Intranet Quorum (replaced WebCIMS)	February 22, 2010
VAKN	VA Knowledge Network	February 10, 2004
VALERI	VA Loan Electronic Reporting Interface	July 21, 2009
VA-LMS	VA Learning Management System	February 10, 2004
VALNET	VA Library Network	Added prior to March 2003
VALO	VA Learning Online	Added prior to March 2003
VALOR	Veterans Affairs Learning Opportunities Residency Program	Added prior to March 2003
VALU	VA Learning University	Added prior to March 2003
VALUE	Veterans Affairs Longitudinal Undergraduate medical Education	October 29, 2015
VAM	Voice Access Modernization	May 10, 2010
VAM	Vehicle Allocation Methodology	October 20, 2011
VAMAN	Voice Assisted Manikin	December 14, 2016
VAMC	VA Medical Center	April 15, 2010
VA-MDNS	VA Medical Device Nomenclature System	December 15, 2016
VAMF	VA Mobile Framework	February 06, 2015
VAMHCS	VA Maryland Health Care System	Added prior to March 2003

VAMROC	Veterans Affairs Medical and Regional Office Center	Added prior to March 2003
VAMS	VistA Automated Monitoring System	April 05, 2010
VAN	Value Added Network	July 27, 2004
VANAP	VA Nursing Academic Partnership	April 21, 2016
VANCHCS	VA Northern California Health Care System	Added prior to March 2003
VANDI	VA National Database of Interns	October 11, 2007
VANEED	Veterans Administration National Education for Employee Program	April 23, 2014
VANEED	Veterans Affairs National Education for Employees Program	April 23, 2014
VANOD	VA Nursing Outcomes Database	June 29, 2005
VANPC	VA National Partnership Council	Added prior to March 2003
VANS	VA Notification System	April 17, 2015
VA-NSOC	VA Network and Security Operations Center	October 02, 2007
VANTS	VA Nationwide Teleconferencing System	Added prior to March 2003
VAO	VA Office	Added prior to March 2003
VAO	Virtual Acquisition Office	February 22, 2010
VAONCE	VA Online Certification of Enrollment	July 29, 2009
VAP	VA Police	June 06, 2006
VAP	Ventilator associated pneumonia	December 28, 2005
VAP	Veterans Authorizations and Preferences	June 14, 2011
VAP	Value Added Process	July 27, 2004
VAPA	Veterans Affairs Palo Alto	August 04, 2014
VAPAHCS	VA Palo Alto Health Care System	January 11, 2005
VAPD	VA Police Department	November 30, 2007
VAPI	VA Protected Information	June 12, 2006
VAPIHCS	Veterans Affairs Pacific Island Health Care System	March 29, 2004
VAPOR	Veterans Affairs Pharmacists Organized for Research	December 13, 2006
VAPS	Veterans Administration Police System	December 10, 2014
VAPSHCS	VA Puget Sound Health Care System	Added prior to March 2003
VARA	Veterans Affairs Rheumatoid Arthritis	December 16, 2011
VARC	Veterans Addiction Recovery Center	April 23, 2014
VARC	Veterans Addiction Recovery Center	May 07, 2014
VARI	Veterans Administration Revenue Information	June 03, 2003
VARO	VA Regional Office	Added prior to March 2003
VASC	Vascular	August 14, 2014
VASH	VA Supported Housing	April 23, 2014
VASI	VA Systems Inventory	April 23, 2014
VASQIP	VA Surgical Quality Improvement Program	March 28, 2011
VASQUIP	Veteran Affairs Surgical Quality Improvement Program	December 15, 2016
VAST	Veteran Affairs Site Tracking	May 18, 2005
VATAMMCS	Vision Analysis Team Aim Map Measure Change Sustain	November 23, 2011
VA-TAMMCS	Vision-Analysis-Team-Aim-Map-Measure-Change-Sustain/Spread	June 21, 2010

VATAS	VA Time and Attendance System	September 27, 2010
VAUSH	Veterans Affairs Under Secretary of Health	May 07, 2014
VAVS	VA Voluntary Service	Added prior to March 2003
VB	Visual Basic	Added prior to March 2003
VBA	Veterans Benefit Administration	July 30, 2015
VBAFS	VBA Finance Staff	October 04, 2010
VBASLCY	VBA Salt Lake City	April 15, 2014
VBAT	Veterans Benefits Audit Team	April 23, 2014
VBC	veterans benefits counselor	June 28, 2004
VBECs	Vista Blood Establishment Computer Software	August 12, 2003
VBIT	Veterans Benefits Information Technology	April 11, 2007
VBMAP	Veterans Benefits Management Assistance Program	April 23, 2014
VBMS	Veterans Benefits Management System	September 20, 2010
VBMS-A	Veterans Benefits Management System - Awards	September 23, 2014
VBMS-C	Veterans Benefits Management System - Correspondence	April 18, 2014
VBMS-CORE	Veterans Benefits Management System-Core	June 16, 2015
VBMS-R	Veterans Benefits Management System - Rating	August 11, 2015
VBRS	Veterans Benefits Reference System	February 24, 2009
VC	Veterans Center	Added prior to March 2003
VCAA	Veterans Claims Assistance Act of 2000	May 08, 2008
VCAC	Veterans Claims Adjudication Commission	Added prior to March 2003
V-CAMP	Veterans' Cognitive Assessment and Management Program	April 10, 2014
VCE	Veterans Claims Examiner	August 12, 2009
VCED	Veterans Community Employment Development	August 10, 2010
VCHI	VISN Chief of Health Informatics	March 23, 2015
V-CHI	VISN-CHIO Subcommittee	July 30, 2015
VCHIO	Veterans Consumers Health Informatics Office	December 15, 2016
VCIOC	VHA VISN CIO Council	October 20, 2003
VCIP	Veterans Claims Intake Program	May 01, 2014
VCJCS	Vice Chairman of the Joint Chiefs of Staff	May 07, 2014
VCL	Veterans Crisis Line	September 04, 2015
VCL	Veterans Choice List	June 16, 2015
VCP	Veteran-Community Partnership	October 22, 2015
VCS	Virtual Collaboration Site (IPO)	May 07, 2014
VCS	Video Communication Server	November 08, 2010
VCS	Vista Contracting Services	February 25, 2008
VCS	Veterans Canteen Service	July 27, 2004
VCSB	Voluntary Consensus Standards Bodies	September 14, 2009
VCSFC	Veterans Canteen Service Finance Center	Added prior to March 2003
VCSRO	Veterans Canteen Service Regional Office	Added prior to March 2003

VCWG	VAleo Convenors Working Group	Added prior to March 2003
VDBSS	VISTA/Defense Blood Standard System	Added prior to March 2003
VDC	VONAPP Direct Connect	April 03, 2014
VDD	Version Description Document	March 31, 2009
VDD	Version Description Document	April 09, 2009
VDEF	VistA Data Extraction Framework	March 20, 2003
VDEM	VistA Data Extraction Mapping	July 27, 2004
VDF	VistA Data Feeds	April 15, 2014
VDI	Virtual Desktop Infrastructure	April 23, 2014
VDIM	VHA Dynamic Integration Model	October 02, 2007
VDL	VA Software Document Library	August 16, 2011
VDL	Virtual Due List	May 24, 2010
VDL	Vista Documentation Library	May 18, 2005
VDR	VA/DoD Identity Repository	April 23, 2014
VDR	Virtual Data Repository	June 25, 2014
VDR	Virtual Disaster Recovery	January 21, 2016
VDS	Vocational Development Specialist	December 08, 2016
VDSI	VistA Data Systems & Integration	July 27, 2004
VDVS	Virginia Department of Veterans Services	December 14, 2016
VE	VIETNAM ERA	April 17, 2015
VEAP	Veterans Education Assistance Program	Added prior to March 2003
VEHU	VHA eHealth University	May 18, 2005
VEI	Veterans Employment Initiative	April 23, 2014
VEIN	Veterans Educators Integrated Network	July 21, 2004
VEMS	Veterans Enterprise Management System	May 08, 2014
VEOA	VEOA Eligibles	July 30, 2015
VEOA	veterans employment opportunity act	July 30, 2015
VERA	Voluntary Early Retirement Authority	April 30, 2014
VERA	Veterans Equitable Resource Allocation	Added prior to March 2003
VERC	Veterans Engineering Resource Center	June 27, 2011
VERDICT	Veterans Evidence-Based Research Dissemination and Implementation Center	May 14, 2007
VERIS	Veterans Exam Request Information System	July 27, 2004
VERP	Veteran Enrollment Rework Project	December 14, 2016
VERP	Veterans Enrollment Rework Project	December 14, 2016
VES	Veterans Evaluation Services	April 23, 2014
VESO	Veterans Employment Service Office	April 23, 2014
VETS	VHA Enterprise Terminology Services	June 04, 2004
VETSNET	Veterans Service Network	April 23, 2014
VEV	Vietnam Era Veterans	Added prior to March 2003
VFA	Veterans Financial Assessment	February 10, 2004

VFIB OR V FIB OR VF	VentricularFibrillation	August 14, 2014
VFIRP	Veteran-Focused Internet Redesign Project	Added prior to March 2003
VFW	Veterans of Foreign Wars	Added prior to March 2003
VG	Ventrogluteal	April 21, 2016
VGIA	Veteran-Guest Internet Access	July 06, 2010
VGLI	Veterans Group Life Insurance	Added prior to March 2003
VH	VETERANS HOME	November 18, 2015
VHA	Veterans Health Administration	Added prior to March 2003
VHACO	Veterans Health Administration Central Office	September 20, 2010
VHAIP	VHA Innovation Program	April 15, 2010
VHEC	Veterans Health Education Coordinator	November 08, 2010
VHEI	Veterans Health Education and Information	July 25, 2006
VHF	Very High Frequency	December 15, 2005
VHIC	Veteran Health Identification Card	April 23, 2014
VHIC	Veterans Health ID Card	April 23, 2014
VHIE	Veterans Health Information Exchange	December 15, 2016
VHIM	VHA Health Information Model	October 04, 2004
VHIT	Veterans Health Information Technology	March 01, 2007
VHL	Veterans Health Libray	September 14, 2011
VHP	Veterans Health Plan	Added prior to March 2003
VHS	Veterans Health Study	Added prior to March 2003
VI	Veteran Industries	October 05, 2009
VIA	VistA Integration Adapter	October 21, 2014
VIC	Veteran Identification Card	Added prior to March 2003
VICTARS	Veterans Insurance Claims Tracking and Response System	December 14, 2016
VICTORS	Visual Impairment Services to Optimize Remaining Sight	January 03, 2007
VIDC	VistA Imaging Display Client	August 17, 2005
VIE	VistA Interface Engine	July 27, 2004
VIE	Vitria Interface Engine	August 11, 2006
VIERS	Veteran Information/Eligibility Record Services	August 14, 2014
VIF	VHA Information Factory	December 13, 2006
VIM	Veterans Information Model	May 26, 2011
VIMM	VistA Immunizations	March 23, 2015
VINCI	VA Informatics and Computing Infrastructure	March 15, 2010
VIP	Veteran Information Portal	April 17, 2007
VIP	vocational integration program	August 03, 2011
VIP	Very Important Person	July 27, 2004
VIP	VistA Intake Program	November 18, 2015
VIP	Veteran-focused Integration Process	December 15, 2016
VIP	Veteran-Focused Integration Process	December 15, 2016

VIP	Veteran-focused Integration Process	April 21, 2016
VIPR	Veteran-Focused Integration Process Request	December 14, 2016
VIQ	VA Intranet Quorum	May 01, 2014
VIREC	VA Information Resource Center	Added prior to March 2003
VIRMSS	VHP Information Resources Management Support Service	Added prior to March 2003
VIRO	Veterans Informatics Resource Office	August 15, 2007
VIS	Veteran's Information Solution	May 27, 2016
VIS	Veterans Information System	February 07, 2005
VISN	Veterans Integrated Service Network	Added prior to March 2003
VISOR	Visual Impairment Services Outpatient Rehabilitation	June 15, 2009
VIST	Visual Impairment Services Team	August 17, 2010
VIST	Visual Impairment Services Team	Added prior to March 2003
VISTA	Veterans Health Information Systems and Technology Architecture	Added prior to March 2003
VITALS	Veterans Information Technology Acquisition of Lifecycle Solution	January 25, 2008
VITAS	Veterans Implant Tracking & Alert System	May 05, 2010
VIVA	Veterans Information and Verification Access	Added prior to March 2003
VIX	VistA Imaging Exchange	October 22, 2009
VJO	Veterans Justice Outreach	June 01, 2010
VLER	Virtual Lifetime Electronic Record	April 30, 2009
VLER	Virtual Lifetime Electronic Record	April 21, 2016
VLJ	Veterans Law Judge	July 20, 2011
VLSN	VISN Lead Surgical Nurse	December 15, 2016
VM	VM	December 21, 2011
VM	Virtual Machine	July 27, 2004
VM MSG	voice mail message	April 10, 2014
VMEC	VistA Maintenance & Expertise Center	February 11, 2005
VMIT	VA OED Memorial Affairs Information Technology	November 30, 2007
VMLI	Veterans Mortgage Life Insurance	April 03, 2014
VMM	Value Measuring Methodology	October 16, 2006
VMP	VistA Maintenance Project	December 28, 2005
VMS	Virtual Memory System	February 01, 2005
VNA	Visiting Nurse Association	April 01, 2008
VOA	Veteran's On-Line Application	May 27, 2016
VOA	Virtual Office Acquisition	March 14, 2011
VOB	Versioned Object Base (IBM Rational ClearCase Tool)	October 25, 2010
VOIP	Voice Over Internet Protocol	January 09, 2006
VONAPP	Veterans Online Application	July 27, 2004
VOR	Veterans Integrated Service Network (VISN) Obligation Report	April 23, 2014
VOR	VETSNET Operations Reports	March 01, 2011
VORP	VISN ONGOING READINESS PROGRAM	April 10, 2014
VORS	Veterans Outreach Reporting System	April 21, 2016

VOSB	Veteran-Owned Small Business	January 23, 2007
VOVA	Voice of VA	October 20, 2011
VOW	Veterans Opportunity to Work	April 17, 2014
VoxML	Voice Markup Language	May 28, 2016
VP	Veteran Programs	February 25, 2008
VPFS	Veterans Personal Finance System	April 24, 2003
VPID	Veterans Affairs Person Identifier	July 27, 2004
VPN	Virtual Private Network	Added prior to March 2003
VPR	Virtual Patient Record	July 29, 2004
VPS	Veteran Point of Service	March 24, 2011
VR&C	Vocational Rehabilitation and Counseling	Added prior to March 2003
VR&E	Vocational Rehabilitation and Employment	April 06, 2007
VRAM	VistA Remote Access Management	April 18, 2014
VRAP	Veteran Retraining Assistance Program	May 01, 2014
VRAP	Veterans Retraining Assistance Program	May 07, 2014
VRB	Value Review Board	Added prior to March 2003
VRC	Vocational Rehabilitation Counselor	April 23, 2014
VRC	Veteran Recovery Center	December 15, 2016
VRC	Veteran Recovery Center	December 15, 2016
VRHAC	Veterans Rural Health Advisory Committee	February 02, 2011
VRHRC	Veterans Rural Health Resource Centers	October 05, 2009
VRI	Veterans Reopened Life Insurance	April 03, 2014
VRM	Veterans Record Management	January 21, 2010
VRM	Veteran Resource Management	June 19, 2007
VRM	Veterans Relationship Management	April 07, 2011
VRS	Vocational Rehabilitation Specialist	August 21, 2008
VRS	Vendor Registration System	July 27, 2004
VRSS	Veteran Re-Entry Search Service	April 23, 2014
VRUM	VistA Resource Utilization Management	May 19, 2015
VS	vital signs	March 23, 2015
VSA	VistA Service Assembler	April 23, 2014
VSAC	Value Set Authority Center	April 18, 2014
VSAT	Very Small Aperture Terminal	February 04, 2010
VSF	Virtual Suggestion Box	April 30, 2014
VSC	Veterans Service Center	July 27, 2004
VSC	Veteran Service Commission	December 14, 2016
VSCM	Veteran Service Center Manager	March 15, 2010
VSE	Vista Scheduling Enhancements	December 10, 2014
VSH	Virtual Server Hosts	April 23, 2014
VSHO	VHA Servicing Human Resources Office	April 23, 2014

VSI	Voluntary Separation Incentive	April 23, 2014
VSIP	Voluntary Separation Incentive Payments	April 30, 2014
VSLI	Veterans' Special Life Insurance	July 14, 2010
VSO	Veterans Service Officer	April 23, 2014
VSO	Veterans Service Organizations	Added prior to March 2003
VSR	Veteran Service Representative	Added prior to March 2003
VSS	Voluntary Service System	April 10, 2003
VSS	Vital Signs Stable	April 15, 2010
VSSC	VHA Support Service Center	May 16, 2006
VTa	Veterans Tracking Application	April 11, 2007
VTACH OR V TACH	Ventricular Tachycardia	August 14, 2014
VTC	Video Teleconferencing	July 27, 2004
VTC	Veterans Treatment Court	October 22, 2015
VTE	Venous Thromboembolism	December 01, 2009
VTE	Virtual Terminal Emulator	December 01, 2009
VTN	Veterans Transportation Network	May 24, 2011
VTs	Veterans Transportation Service	November 18, 2010
VTs	Virtual Tape Subsystem	April 23, 2014
VUID	Veterans Health Administration Unique Identifier	July 27, 2004
VVA	Virtual VA	April 23, 2014
VVO	Verified verbal order	October 21, 2014
VWM	VHA Work Measurement	March 05, 2009
W		top
W/C	wheel chair	October 22, 2015
W/O OR W/O	with out	August 04, 2014
W3C	World -Wide Web Consortium	Added prior to March 2003
WAFPS	Web Automated Folder Processing Systems	December 16, 2011
WAH	Work At Home	January 21, 2016
WAIS	Wechsler Adult Intelligence Scale	April 18, 2014
WAIS	Wide Area Information Service (Web indexing & searching)	Added prior to March 2003
WAM	Web Access Manager	April 17, 2014
WAMC	Womack Army Medical Center	April 11, 2007
WAN	Wide Area Network	Added prior to March 2003
WAN FOG	Wide Area Network Follow-on Work Group	Added prior to March 2003
WAP	Wireless Application Protocol	July 27, 2004
WARM	Web Automated Reference Material System	December 14, 2016
WARTAC	Warrior Training Advancement Course	December 14, 2016
WARTAC	Warrior Training Advance Course	December 15, 2016
WASA	Web Application Security Assessment	July 30, 2015
WASR	Web Application Status Report	May 19, 2015

WATCH	Women's Assessment Tool for Comprehensive Health	December 15, 2016
WAVE	Web Automated Verification of Enrollment	July 27, 2004
WB	Weight Bearing	April 23, 2014
WBLS	Web Based Loan Summary	July 14, 2010
WBNB	Wideband Narrowband	Added prior to March 2003
WBS	Work Breakdown Structure	July 27, 2004
WBT	Web-Based Training	February 18, 2010
WC/OSH MIS	Workers Comp/Occupational Safety Health Management Information System	February 18, 2010
WCCC	Woman's Comprehensive Care Center	November 14, 2011
WCHIP	Women's Comprehensive Health Care Implementation Plan	May 27, 2016
WCNC	Washington Crossing National Cemetery	March 14, 2011
WCO	Web Communications Officer	March 21, 2014
WCP	Workers Compensation Program	June 11, 2014
WDDE	Ward Drug Dispensing Equipment	November 09, 2004
WDDX	Web Dynamic Data Exchange	Added prior to March 2003
WEAMS	Web Enabled Approval Management System	December 03, 2009
WEBALPS	WEB based Automated Loan Processing System	July 14, 2010
WEBCIMS	Web Correspondence & Issues Management System	July 27, 2009
WED	Wednesday	August 14, 2014
WEDI	Workgroup for Electronic Data Interchange	April 27, 2004
WFL	Within Functional Limits	September 23, 2014
WFM	Work Force Management	December 14, 2016
WH PCP	Women's Health Primary Care Provider	May 27, 2016
WHEI	Women's Health Evaluation Initiative	December 15, 2016
WHEN	Weekends, holidays, evenings, nights	April 17, 2014
WHO	World Health Organization	April 17, 2014
WHYMPI	Haven-Yale Multidimensional Pain Inventory	April 12, 2010
WIGI	Within-Grade Increase	February 18, 2010
Windows NT	Windows New Technology	Added prior to March 2003
WIP	Work in Process	May 13, 2010
WIPT	Working Integrated Project Team	Added prior to March 2003
WIR	Wireless Infrastructure Replacement	December 27, 2010
WITS	Work Intake and Tracking Systems	February 18, 2010
WITS	Workforce Information Systems (PAID)	April 05, 2005
WK	week	January 21, 2016
WLA	West Los Angeles	April 17, 2014
WM	With Meals	April 21, 2016
WMCO	Workforce Management and Consulting Office	July 17, 2008
WMD	Weapons of Mass Destruction	March 24, 2003
WMIS	Wireless Controlled Substances	Added prior to March 2003

WML	Wireless Markup Language	July 27, 2004
WMTS	Wireless Medical Telemetry Services	Added prior to March 2003
WNL	Within Normal Limits	October 31, 2007
WNR	Will Not Reimburse	December 08, 2016
WO	Write Off	July 20, 2010
WOC	Without Compensation	March 14, 2005
WOFT	Warrant Officer Flight Training	December 15, 2016
WPI	Wholesale Price Index	May 13, 2010
WPMEA	Workforce Planning, Management and Employee Administration	February 22, 2010
WRAH	Walter Reed Army Hospital	December 14, 2005
WRAMC	Walter Reed Army Medical Center	December 13, 2006
WRAP	Wellness Recovery Action Plan	April 18, 2014
WRIISC	War-related Illness and Injury Study Centers	October 05, 2004
WSDL	Web Services Description Language	March 31, 2009
WSIP	(VA) Web Search Improvement Project	Added prior to March 2003
WSRR	WebSphere Registry and Repository	December 15, 2016
WT	weight	February 06, 2015
WTEMS	What The Evidence Must Show	April 23, 2014
WVCS	Women Veterans Cohort Study	December 16, 2011
WVCS	Women Veterans Cohort Study	December 16, 2011
WVHSHG	Women Veterans Health Strategic Healthcare Group	February 18, 2010
WVPM	Women Veterans Program Manager	July 06, 2009
WWI	World War I	July 27, 2004
WWII	World War II	July 27, 2004
WWP	Wounded Warriors Project	February 18, 2010
WWU	Weighted Work Unit	Added prior to March 2003
WWW	World Wide Web	Added prior to March 2003
WYSIWYG	What you see is what you get	Added prior to March 2003
X		top
X11	An implementation of X-Windows System	July 27, 2004
X12	Identification number for ANSI standard committee and the standards the committee issues	July 27, 2004
XACML	Extensible Access Control Markup Language	June 08, 2005
XMI	XML Metadata Interchange	July 27, 2004
XML	Extensible Mark-up Language	Added prior to March 2003
XML XQL	Extensive Markup Language XML Query Language	July 27, 2004
XRT	Radiation therapy	June 16, 2015
XSL	Extensible Stylesheet Language	Added prior to March 2003
XUA	Cross Enterprise User Assertion	June 21, 2010
Y		top

Y2K	Year 2000	Added prior to March 2003
Z		top
ZIFA	Zachman Institue for Framework	July 27, 2004
ZIP	Zone Improvement Program	July 06, 2010

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U.S. Department
of Veterans Affairs

2017

Functional Organization Manual - v4.0

Description of Organization
Structure, Missions, Functions,
Activities, and Authorities

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Introduction

The Functional Organization Manual (FOM) is the authoritative source that documents the current organization structure, missions, functions and tasks of the Department of Veterans Affairs (VA) and its organizations. It is a core reference document for the Department to describe what gets done by whom, for whom, and under what authorities. It is a “living document” that, over time, will reflect key changes that lead to refined organizational processes and procedures, and further enhance synchronized and coordinated actions across the Department to ensure optimal execution of the VA mission and strategy.

The FOM is available on the VA intranet in a searchable repository. The Office of Policy, within the Office of Policy and Planning, is responsible for the maintenance and updating of the FOM.

BACKGROUND

- VA was established as an independent agency under the President by Executive Order (EO) 5398 on July 21, 1930, and was elevated to Cabinet level on March 15, 1989, (Public Law 100-527).
- The Department’s mission is to serve America’s Veterans and their families with dignity and compassion, and to be their principal advocate in ensuring that they receive medical care, benefits, social support, and lasting memorials promoting the health, welfare, and dignity of all Veterans in recognition of their service to this Nation.
- VA is the second largest Federal department and has over 340,000 employees. Among the many professions represented in the vast VA workforce are physicians, nurses, counselors, statisticians, architects, computer specialists, and attorneys. As advocates for Veterans and their families, the VA community is committed to providing the very best services with an attitude of caring and courtesy.
- VA comprises a Central Office (VACO), which is located in Washington, DC, and field facilities throughout the Nation administered by its three major service line organizations: Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration.
- Services and benefits are provided through a nationwide network of 144 hospitals, 1,232 outpatient clinics, 300 Vet Centers, 56 Regional Offices, and 240 National, State or Tribal Cemeteries. *(Statistics current as of September 30, 2016).*
- The Secretary of VA (SECVA) identified three strategic goals for VA to focus on as the means to improve services to Veterans and their families and to improve management in the Department. These goals are the components of the 2014-2020 VA Strategic Plan:
 - Strategic Goal 1: Empower Veterans to Improve Their Well-being.
 - Strategic Goal 2: Enhance and Develop Trusted Partnerships.
 - Strategic Goal 3: Manage and Improve VA Operations to Deliver Seamless and Integrated Support.

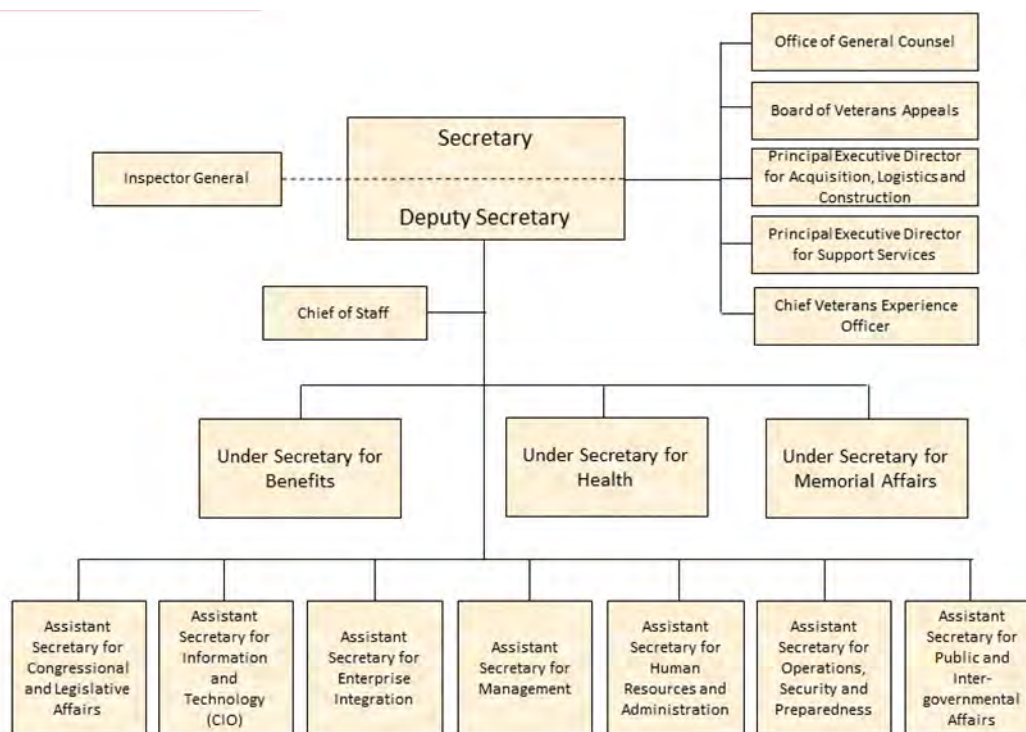


Figure 1 - VA Organization Chart.

[Click here for an alternate representation of the chart.](#)

ORGANIZATION OF THE DEPARTMENT

Secretary of Veterans Affairs (SECVA)

The **Secretary of Veterans Affairs (SECVA)** is the head of VA and is appointed by the President, by and with, the advice and consent of the Senate. The SECVA is responsible for the proper execution and administration of all laws administered by the Department and for the control, direction, and management of the Department.

Deputy Secretary of Veterans Affairs (DEPSECVA)

The **Deputy Secretary of Veterans Affairs (DEPSECVA)** serves as the second in command and Chief Operating Officer for the Department. The DEPSECVA directs the policy and operations of the Department and provides broad direction to the Department's Staff Offices, ensuring coordinated action and conformance with the Secretary's directives.

Chief of Staff of Veterans Affairs (COSVA)

The **Chief of Staff of Veterans Affairs (COSVA)** synchronizes and coordinates SECVA policy guidance and direction with VA's Administrations, Staff Offices, and key officials. Through the Deputy Chief of Staff, COSVA oversees OSVA staff, including several senior advisors and special assistants to ensure effective and efficient support to the SECVA and DEPSECVA.

Administrations and Staff Offices: The Department has three Administrations that provide for the delivery of services and benefits, seven Assistant Secretaries who advise and support the SECVA and the Administrations and Staff Offices that provide specific assistance to the SECVA.

The three Administrations are Veterans Health Administration, Veterans Benefits Administration and National Cemetery Administration. The head of each Administration reports to the SECVA through the DEPSECVA. These Administrations give centralized program direction to field facilities that provide diverse program services to Veterans and their families. Further, each Administration has Central Office components that support the Administration's operations. This organizational structure reflects a basic management approach of centralized policy direction, complemented by consistent decentralized execution.

The seven Assistant Secretaries serve as the principal staff advisors to the SECVA and DEPSECVA and oversee or administer programs in their respective areas of responsibility.

Assistant Secretary for Management

The **Assistant Secretary for Management** serves as the Chief Financial Officer (CFO) for the Department. As the CFO, the Assistant Secretary is responsible for financial management, budget administration, resources planning, business oversight activities, and monitoring the development and implementation of VA's performance measures. The Assistant Secretary serves as the Department's principal advisor for budget, fiscal, capital and green program management (energy, environment, transportation/fleet, and sustainability) policy, and supports the VA governance bodies with regard to capital-asset portfolio management and implementing the strategic capital-asset planning process.

Assistant Secretary for Information and Technology

The **Assistant Secretary for Information and Technology** serves as the Chief Information Officer (CIO) for the Department. As the CIO, the Assistant Secretary is responsible for the vision, management, operation, and execution of VA's Office of Information and Technology (OIT) and its resources, delivering adaptable, secure and cost effective technology services to the Department. The Assistant Secretary serves as the principal advisor to the SECVA on matters relating to information and technology management in the Department as delineated in P.L. 104-106, the Clinger-Cohen Act, the Paperwork Reduction Act, Chapter 35 of Title 44 United States Code (U.S.C.) and any other associated legislated or regulatory media.

Assistant Secretary for Enterprise Integration

The **Assistant Secretary for Enterprise Integration** is responsible for leading and orchestrating the continuous improvement of Veterans and employee experience through effective enterprise integration of people, processes, technology; innovations, and maturing organizational management capabilities. The Assistant Secretary is responsible for overseeing Department-level activities related to strategy development, strategic planning, integrated enterprise planning, performance management, risk management, performance improvement, innovations, transformation, policy management, policy analysis, policy research, interagency collaboration and coordination with DoD and other federal partners, actuarial studies and assessments, VA statistics, and data analytics. The Assistant Secretary is also responsible for the Nation's official estimates and projections of the Veteran population.

Assistant Secretary for Operations, Security and Preparedness

The **Assistant Secretary for Operations, Security and Preparedness** is the principal advisor to the SECVA and DEPSECVA on VA's capability and readiness to continue services to Veterans and their families, respond to contingency support missions to the DoD and other Federal agencies engaged in emergency-response activities and respond effectively during national emergencies. The Assistant Secretary is responsible for coordinating VA's emergency management, preparedness, identity management, physical security, personnel security and suitability, police services and law enforcement activities, and for

ensuring compliance and resource management in the OSP so the Department can continue to perform mission-essential functions under all circumstances across the spectrum of threats.

Assistant Secretary for Human Resources and Administration

The Assistant Secretary for Human Resources and Administration is responsible for providing VA-wide responsibilities to such programs as human resources management, diversity and inclusion, discrimination complaint resolution, labor-management relations, VA's Learning University, corporate senior executive management, and general administrative support (primarily services to VA Central Office). The Assistant Secretary serves as the Department's designated Agency Safety and Health Official and is responsible for administering the Occupational Safety and Health and Workers' Compensation programs. The Assistant Secretary also serves as the Department's Chief Human Capital Officer, advising and assisting the SECVA in carrying out VA's responsibilities for selecting, developing, training, and managing a high-quality workforce in accordance with merit systems principles.

Assistant Secretary for Public and Intergovernmental Affairs

The **Assistant Secretary for Public and Intergovernmental Affairs** develops, maintains, and communicates the Department's message through media relations and public, intergovernmental, and Veteran engagement to empower Veterans and their families. The Assistant Secretary is responsible for overseeing the Department's communications with Veterans, the general public, VA employees, and the news media. The Assistant Secretary is also responsible for providing VA leadership with strategic advice, guidance, and information by fostering partnerships, and acting as liaison between state, local, tribal, insular, and international governments. The Office of the Assistant Secretary for Public Affairs works to build confidence in VA and its readiness to serve America's Veterans of all generations.

Assistant Secretary for Congressional and Legislative Affairs

The **Assistant Secretary for Congressional and Legislative Affairs** acts as principal advisor to SECVA and DEPSECVA concerning all legislative and congressional liaison matters. The Assistant Secretary has overall responsibility for the plans, policies, goals, and is responsible for directing the Office of Congressional and Legislative Affairs. The Assistant Secretary is the principal coordinator of VA's legislative program development and is responsible for ensuring Departmental compliance with congressionally mandated reports and for serving as the point-of-contact with the Government Accountability Office (GAO).

Authorities

38 U.S.C. Chapter 3

Office of the Secretary of Veterans Affairs

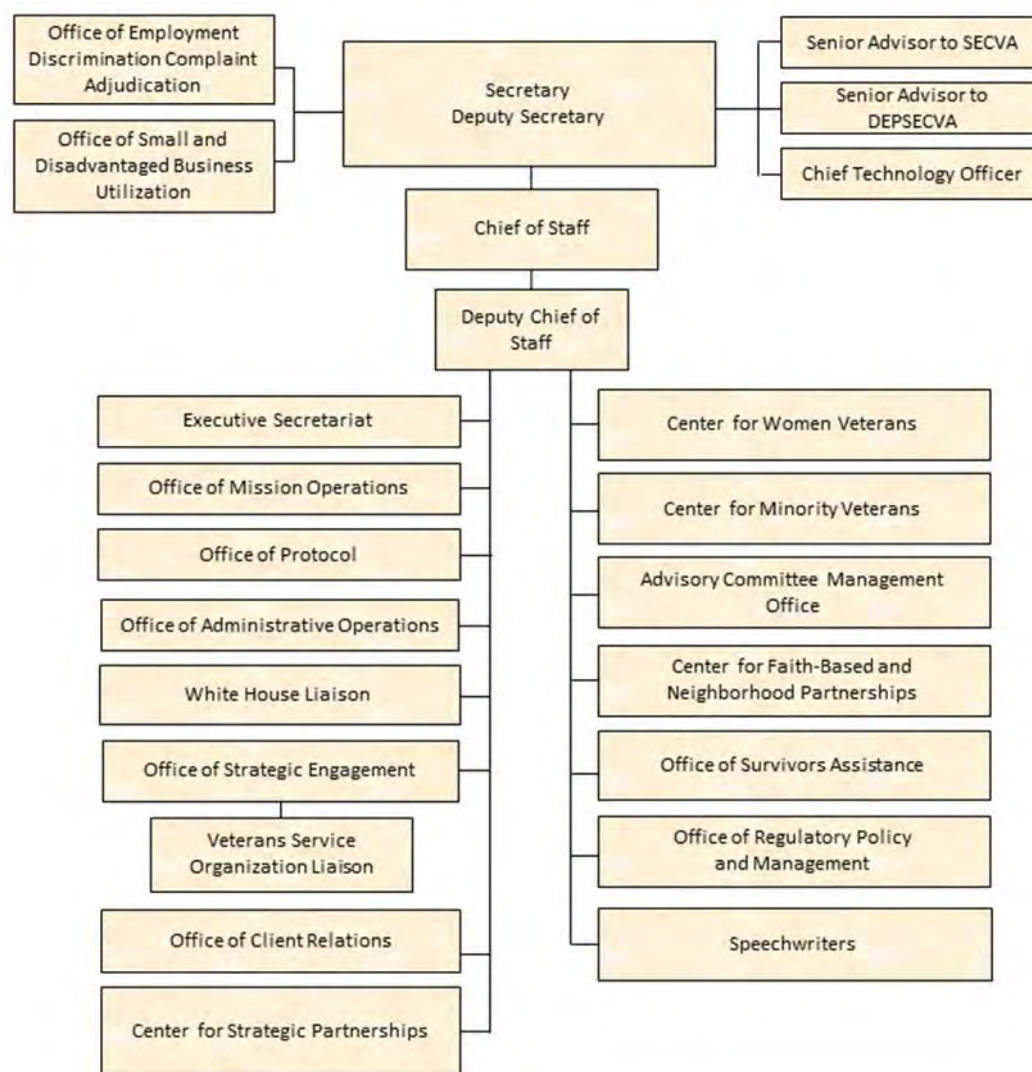


Figure 2 - Office of the Secretary

[Click here for an alternate representation](#)

Office of the Secretary

Overview

The Office of the Secretary (OSVA) is headed by the Secretary (SECVA) and includes the Deputy Secretary for Veterans Affairs (DEPSECVA), Chief of Staff (COSVA), the Executive Secretariat, senior advisors and several special focus centers and offices. Legal authority is vested, by 38 U.S.C., in the SECVA, who generally may delegate it to other VA officials in order to carry out the Department's

missions. The DEPSECVA serves as the second in command and Chief Operating Officer for the Department. The COSVA synchronizes and coordinates SECVA policy guidance and direction with VA's Administrations, Staff Offices, and key officials.

Functions and Activities

- DEPSECVA directs the policy and operations of the Department and provides broad direction to the Department's Staff Offices, ensuring coordinated action and conformance with the Secretary's directives.
- DEPSECVA oversees the activities of the Executive Director of the Office of Acquisition, Logistics, and Construction (OALC).
- DEPSECVA manages the implementation of VA's Veteran Access, Choice, and Accountability Act of 2014.
- COSVA oversees OSVA staff, including several senior advisors and special assistants to ensure effective and efficient support to the SECVA and DEPSECVA and the Department, as appropriate.
- COSVA participates in the Department's governance process.

Executive Secretariat

Overview

The Executive Secretariat is VA's central coordinating point for all staff actions addressed to, and emanating from, the SECVA, DEPSECVA, and COSVA. The Executive Secretariat employs executive writers who draft documents and review internal communications for signature by the SECVA, DEPSECVA, and COSVA.

Functions and Activities

- Serves as the principal staff-action control point for the Department on internal and external items and directs/assigns all administrative tasks on behalf of the SECVA. Coordinates with other Federal agencies and departments on joint letters and memoranda.
- Prepares and presents executive staff actions (responses to Members of Congress, testimony, questions for the record, memoranda for record/understanding/agreements between VA and outside entities, etc.) for review and signature and is VA's repository for the same.
- Is solely authorized to authenticate documents transmitting policy, procedure, or information to the Department "by order of the Secretary." Provides correspondence policy for the Department.
- Serves as the Department's point of contact for the U.S. Office of Special Counsel's disclosure cases and coordinates VA's response.
- Provides records management as the Office of Record for all documents signed by the SECVA, DEPSECVA, and COSVA.

- Receives and processes all Freedom of Information Act (FOIA) and Privacy Act requests for the Office of the Secretary.
- Serves as the Department's point of contact for the Plain Writing Act.

Office of Mission Operations

Overview

The Office of Mission Operations carries out OSVA executive mission support with full responsibility for executive travel, strategic and events planning, and special projects.

Functions and Activities

- Arranges official travel for SECVA, DEPSECVA, COSVA and others as required. Coordinates transportation, security, equipment, and protocol activities while on travel status, including travel arrangements for personnel support staff; processes and maintains official travel accounts.
- Travels with principals when travel coincides with domain responsibilities, and coordinates equipment, capabilities, and personnel to accompany primaries on trips when necessary.
- Serves as SECVA and DEPSECVA liaison with White House Advance Staff.
- Plans, coordinates, and executes events for SECVA, DEPSECVA, and COSVA.

Office of Administrative Operations

Overview

The Office of Administrative Operations carries out OSVA executive administrative support with full responsibility for human resources, budget, financial management, acquisitions, correspondence, information technology, emergency preparedness, and space and property management.

Functions and Activities

- Develops and manages the OSVA budget, to include authority to expend funds as delegated by the COSVA.
- Manages and maintains OSVA property, inventory, and expendable supplies.
- Provides Human Resources guidance and, through coordination with VA Central Office (VACO) Human Resources Services, provides personnel classification and staffing support.
- Manages OSVA's acquisitions process to procure items and services necessary for day-to-day operations of OSVA.
- Plans and coordinates special projects and emergency preparedness activities (e.g., Continuity of Operations Plan).

Office of Protocol

Overview

The Office of Protocol provides protocol and executive services to SECVA, DEPSECVA, and COSVA.

Functions and Activities

- Directs and organizes special ceremonies and events for the VA Central Office that involves executive leadership.
- Escorts dignitaries visiting the executive leadership.
- Provides and organizes related protocol services to include photography and media services for VIP visitors.
- Provides advice and guidance to VACO and field facilities on protocol matters as they relate to visitors, both foreign and domestic, ceremonies, and other special events.

Office of Strategic Engagement

Overview

The Office of Strategic Engagement coordinates and monitors all integrated communications activities across the Department and facilitates engagements with key audiences to achieve effects consistent with VA's interests, policies, and objectives. The Office of Strategic Engagement oversees the Veterans Service Organizations (VSO) Liaison.

Functions and Activities

The Senior Advisor to the Secretary for Strategic Engagement serves as primary advisor on matters related to coordinated internal and external communications. This includes communication and engagement with Veterans, employees, VSOs, NGOs, Congress, inter-governmental partners and media.

- Develops, synchronizes, and coordinates Department communications and engagement strategies.
- Provides guidance and clearance on messaging and overall engagement activities and priorities.
- Synchronizes and coordinates crisis communications actions and special projects and initiatives.
- Advises VA leadership on communications and engagement strategy.

Veterans Service Organizations Liaison

Overview

The Veterans Service Organizations (VSO) Liaison is the Department's primary advisor on matters affecting VSOs and other Veteran advocacy groups. The VSO Liaison is responsible for the Department's day-to-day liaison with those organizations as well as developing proactive strategies for engagements and partnerships with the VSOs. The VSO also articulates the Department's positions on issues affecting America's Veterans.

Functions and Activities

Communicates regularly with VSO officials to ensure VA responds effectively to the needs of the organizations and their members.

- Attends VSO conferences and national conventions and communicates with Veterans concerning issues they feel strongly about.
- Attends VSO members' testimony on Veteran's issues to the House and Senate Veterans Affairs Committees.
- Supports Department leadership in their engagements with VSO and Veteran advocacy groups by developing pre-briefings and topic recommendations.
- Advises the Department leadership regarding VSO policy statements or specific positions on Veterans' issues.
- Assists VSOs in their dealings with other Federal agencies.

Center for Strategic Partnerships

Overview

The Center for Strategic Partnerships leverages resources external to the VA on an effective and consistent basis, at all levels of the Department, to improve the Veteran experience while enhancing productivity and efficiency across the Department. The Center promotes and advances strategic partnerships between VA and external stakeholders through consultation, networking, resource sharing, and collaborative opportunities that benefit VA, Veterans, their families, Caregivers, Survivors, and other beneficiaries.

Functions and Activities

The Center for Strategic Partnerships advises the Secretary and other senior leadership on matters related to responsible and productive partnerships and related programs, issues, and initiatives. It provides external stakeholders with an access point to VA leadership, resources, and VA needs, while also conducting strategic engagement and education.

- Leads strategic partnerships across the Department by maximizing external proposals, empowering employees with effective resources and tools, undertaking proactive engagement with external stakeholders, developing high impact projects, and sustaining, improving, and replicating best practice models.
- Represents OSVA in meetings with key leaders of business, government, philanthropic, nonprofit, and other key stakeholder organizations.
- Encourages and facilitates public-private partnership opportunities through VA initiatives, programs, and services that complement VA's mission, priorities, goals, objectives, and strategies.
- Cultivates and stewards relationships between VA and external stakeholders. Provides consultation to better understand the Department, services provided, the Veteran community

and effective strategies to work with VA. Encourages feedback from stakeholders on key Veteran issues.

Authorities

38 U.S.C. §523

Office of Client Relations

Overview

The Office of Client Relations (OCR) ensures that all incoming executive inquiries (emails, phone calls, and special interest correspondence) from internal and external Clients (Veterans, VA employees, their family members, and external stakeholders) are documented, controlled, and monitored, to provide enterprise awareness and uniform responses in a timely and efficient manner.

Functions and Activities

The Director of Client Relations oversees client inquiries incoming to the SECVA, DEPSECVA, and COSVA and coordinates control and ownership of such among the VA Administrations.

- Establishes control and oversight of all Client inquiries incoming to the Office of the Secretary.
- Ensures timely, uniform, and accurate responses from the VA Administrations.
- Responsible to handle and process Client inquiries through the ExecVA Contact Management Tracking System to maximize VA's efficiency in addressing Client concerns.
- Identifies and analyzes trends in Client concerns for inter-Administration reporting, consultation, and advisement.

White House Liaison

Overview

The White House Liaison oversees and coordinates the political appointment process and serves as liaison to the White House.

Functions and Activities

- Serves as liaison between VA and the White House Presidential Personnel Office coordinating the political appointment process.
- Works closely with political appointees to coordinate White House activities and events.
- Works closely with the White House on special projects.

Office of Regulatory Policy and Management

Overview

The primary mission of the Office of Regulatory Policy and Management (ORPM) is to provide centralized management and control for the formulation and publication of all VA rulemakings. ORPM

ensures rulemakings are drafted clearly, comply with applicable legal and technical requirements, and are published in a timely manner. ORPM also advises SECVA and senior officials on all matters related to rulemaking including coordination within VA, with other Federal agencies, and with Congress.

Functions and Activities

- Trains VA program offices on the rulemaking process, including whether to engage in rulemaking, how to resolve policy questions, how to draft a rulemaking, and the concurrence process.
- Assists in developing rulemaking strategies to respond to new legislation and inquiries from Congress or the public concerning regulatory matters.
- Works with VA program offices to ensure they have planned for implementing each rulemaking (including adequate resources—financial, staffing, and information technology (IT)).
- Tracks and facilitates the movement of each rulemaking through concurrence within VA and at the Office of Management and Budget (OMB).
- Manages the publication of rulemakings in the Federal Register and receives and responds to public comments.

Speechwriters

Overview

Speechwriters prepare, review, revise, and edit executive communications, including speeches, congressional testimony, select personal correspondence, communications posted on websites and messages for publication in myriad forums for the SECVA, DEPSECVA, and COSVA.

Functions and Activities

- Advises senior leaders on subject and content of written communications, in addition to creating original written products and editing others' written products.
- Tracks all speaking engagements and ensure products are provided to senior leaders well in advance of events.
- Conducts in-depth research on topics related to all written products. Ensure data and facts are updated, correct, and synchronized/coordinated in products provided to senior leaders.

Center for Women Veterans

Overview

The Center for Women Veterans (CWV) monitors and coordinates VA's health care, benefits, services, and programs for women Veterans. CWV advocates a cultural transformation within VA and the general public to recognize the service and contributions of women Veterans and women in the military, and raises awareness of the responsibility to treat women Veterans with dignity and respect. The CWV Director serves as the primary advisor to the SECVA on all matters related to policy, legislation, programs, issues, and initiatives affecting women Veterans.

Functions and Activities

- Promotes and leads effective collaboration with representatives from the Department's Administrations to examine women Veterans' issues and synchronize activities to advocate full awareness of health care, benefits services, and programs for women Veterans.
- Presents women Veterans' issues for inclusion in the Department's strategic plan. Ensures that health care, benefits services, and programs for women Veterans are part of VA's institutional consciousness.
- Briefs Congress, Veterans Service Organizations (VSO), Non-governmental organizations (NGO) and other community partners on women Veterans' issues.
- Monitors and participates in VA outreach efforts targeting women Veterans.
- Supports the Advisory Committee on Women Veterans with logistical and administrative matters. Coordinates the development of the Advisory Committee on Women Veterans' biennial report to the Secretary and coordinates VA's response to the report's recommendations.
- Develops strategic partnerships with public-private organizations to further amplify programs and services provided by VA to women Veterans and to educate them about women Veterans and help them explore ways to help women Veterans.

Authorities

38 U.S.C., §318

P.L. 103-446, §509

Federal Advisory Committee Act (1972), 5 U.S.C. Appendix 2

Center for Minority Veterans

Overview

The Center for Minority Veterans (CMV) promotes increased access to, and use of, VA services and benefits by minority Veterans.

Functions and Activities

Serves as the principal advisor to the SECVA on the unique needs of minority Veterans:

- Identifies barriers to benefits and health care access, promotes awareness of minority Veteran-related issues, develops strategies for improving minority Veterans' participation in existing VA programs, conducts outreach activities with minority Veteran stakeholders, and coordinates outreach activities conducted by Minority Veterans Program Coordinators (MVPC) assigned to the three VA Administrations.
- Manages the activities of the Advisory Committee on Minority Veterans (ACMV), including site visits and Veterans Town Hall Meetings.
- Conducts outreach to communities with high-minority Veteran populations and minority-serving institutions.

- Consults with the key representatives from major Veterans Service Organizations, local agencies, and other Federal agencies to increase outreach activities to designated minority Veteran groups.
- Conducts joint outreach with other VA Program Offices/Administrations.
- Provides training to MVPC representatives from each VA Administration based on an analysis of best practices and areas for possible improvement. Coordinates outreach activities of MVPCs with local affiliates of national-level minority stakeholders.
- Collaborates with the Center for Faith Based and Community Partnerships to conduct outreach programs to faith based organizations.
- Publicize the results of medical research that is of particular significance to minority Veterans.

Authorities

38 U.S.C.

P.L. 103-446 §510

Federal Advisory Committee Act (1972) 5 U.S.C. Appendix 2

Advisory Committee Management Office

Overview

The Advisory Committee Management Office (ACMO) provides administrative and management support to the Department's 25 Federal Advisory Committees. VA's advisory committees solicit advice and recommendations from outside experts and the public concerning programs for which the Department is responsible for by law.

Functions and Activities

ACMO establishes clear goals, standards, and uniform procedures for Advisory Committee activities:

- Ensures that all VA Advisory Committees comply with the provisions of the Federal Advisory Committee Act and other Federal laws and regulations.
- Ensures that VA Advisory Committee meetings are open to the public as appropriate and announced in the Federal Register.

Authorities

Federal Advisory Committee Act (1972) 5 U.S.C. Appendix 2

Center for Faith-Based and Neighborhood Partnerships

Overview

The mission of the Center for Faith-Based and Neighborhood Partnerships (CFBNP) is to develop partnerships with, provide relevant information to, and expand participation of faith-based, nonprofit, and community/neighborhood organizations in VA programs in order to better serve the needs of Veterans, their families, survivors, caregivers, and other beneficiaries.

Functions and Activities

The CFBNP establishes and cultivates relationships with diverse faith-based, nonprofit and community/neighborhood organizations working as collaborative partners to meet the needs of and to support Veterans, their families, survivors, caregivers, and other beneficiaries.

- Participates in events convened or co-hosted by the White House Office of Faith-Based and Neighborhood Partnerships (WH OFBNP).
- Works collaboratively with other Federal agency Faith-Based Centers to convene and co-host conference calls and outreach events.
- Hosts quarterly conference calls to provide information that will assist faith-based, nonprofit, community/neighborhood organizations in their work with Veterans, their families, survivors, caregivers, and other beneficiaries.
- Convenes and facilitates workshops and break-out sessions at local, regional, and national denominational conferences in coordination with local and regional VA staff.
- Co-hosts VA Regional Outreach Events in partnership with VBA Benefits Assistance Service (BAS) and the Regional Office of the host city. The VA Regional Outreach Event provides information about the programs and services VA provides for Veterans. It also encourages collaboration among attendees and provides them with local VA contacts for future engagement.

Authorities

EO 13342

EO 13199

Office of Survivors Assistance

Overview

Office of Survivors Assistance (OSA) provides support to survivors of Veterans by identifying and informing them of the benefits and services offered by VA.

Functions and Activities

- Serves as primary advisor to the SECVA for all matters related to VA programs, legislative issues, and other initiatives affecting survivors and dependents of Veterans and members of the Armed Forces.
- Ensures that surviving spouses, children, and parents have information on, and access to, all applicable benefits and services under the law. Develops and provides communications materials and products for distribution to internal and external partners and organizations, and advocates for the needs of survivors in the policy and programmatic decisions of VA.
- Builds and maintains collaborative partnerships with local, state, and Federal agencies as well as VSOs, faith-based and community organizations, and other stakeholder groups in order to increase their awareness of benefits and services available to survivors and dependents.

- Develops innovative outreach opportunities to reach survivors who are eligible for, but are not receiving, benefits.
- Participates in a variety of engagements to inform participants of the benefits and services available to survivors.
- Develops and provides communications materials and products for distribution to internal and external partners and organizations.
- Tracks and recommends survivor legislative issues.
- Refers survivors to VA Administrations and Staff Offices to ensure they receive all benefits and services for which they are eligible.

Authorities

P.L. 110-389, Title II, § 222

Office of Employment Discrimination Complaint Adjudication

Overview

The Office of Employment Discrimination Complaint Adjudication (OEDCA), an independent adjudicatory authority created by Congress in 1998, is responsible for issuing timely and high-quality final agency decisions and orders on the substantive merits of employment discrimination complaints filed by employees and applicants for employment.

Functions and Activities

Issues final Department decisions and orders on the substantive merits of employment discrimination complaints filed by employees, former employees, or applicants for employment with the Department.

- Prepares and issues Department final decisions and final orders on the substantive merits of individual and class complaints of employment discrimination, and determines a prevailing party's entitlement to compensatory damages, equitable relief, and attorney fees.
- Reports findings of intentional discrimination or retaliation to the SECVA or DEPSECVA for appropriate follow-up action.
- Refers findings of discrimination to the Assistant Secretary for Human Resources and requests appropriate follow-up regarding disciplinary action.
- Conducts outreach across the Department and with principal Department stakeholders.
- Publishes an annual digest to explain findings of discrimination and offer best practices to avoid these types of instances.

Authorities

38 U.S.C. 319

Office of Small and Disadvantaged Business Utilization

Overview

The Office of Small and Disadvantaged Business Utilization (OSDBU) is the Department's principal liaison to the Small Business Administration (SBA), the Department of Commerce, the General Services Administration (GSA), and the Office of Federal Procurement Policy for matters dealing with small and disadvantaged business activities. OSDBU's mission is to enable Veterans to gain access to economic opportunity by leveraging the federal procurement system and expanding participation of procurement-ready small businesses.

Functions and Activities

Provides verification of eligibility for VA's Veterans First Contracting Program:

- Ensures businesses meet 38 CFR part 74 requirements and are eligible for designation as Service-Disabled Veteran-Owned Small Businesses (SDVOSB) and Veteran-Owned Small Businesses (VOSB). Businesses meeting the eligibility requirements are maintained in the Vendor Information Pages database of verified SDVOSBs and VOSBs.
- Negotiates small business goals with the SBA and with VA component organizations, and recommends final goals to the SECVA and Senior Procurement Council.
- Reviews subcontracting. Makes recommendations to contracting officers to facilitate compliance with VA goals and monitors performance.
- Provides acquisition support. Reviews proposed acquisition strategies and makes recommendations to contracting officers on use of set asides to meet VA small business goals and comply with small business program requirements. Supports small business access to acquisition opportunities by providing access to VA's Forecast of Contracting Opportunities prepared by the Department's acquisition and program offices.
- Assists small businesses in resolving payment or other contracting issues with VA.
- Plans and implements the Direct Access Program, to include the National Veterans Small Business Engagement, to enable small businesses to gain access to VA procurement decision makers.
- Coordinates and participates in outreach events to small businesses that enable them to better understand how to do business with VA.
- Manages the Veteran Entrepreneur Portal to provide resource information to assist VOSBs. Provides VA contracting information and assistance to SDVOSBs, VOSBs, and other small businesses.

Authorities

P.L. 95-507

P.L. 106-50

P.L. 108-183

P.L. 109-461

P.L. 110-389
P.L. 111-275
EO 13360
38 CFR part 74

Office of Inspector General

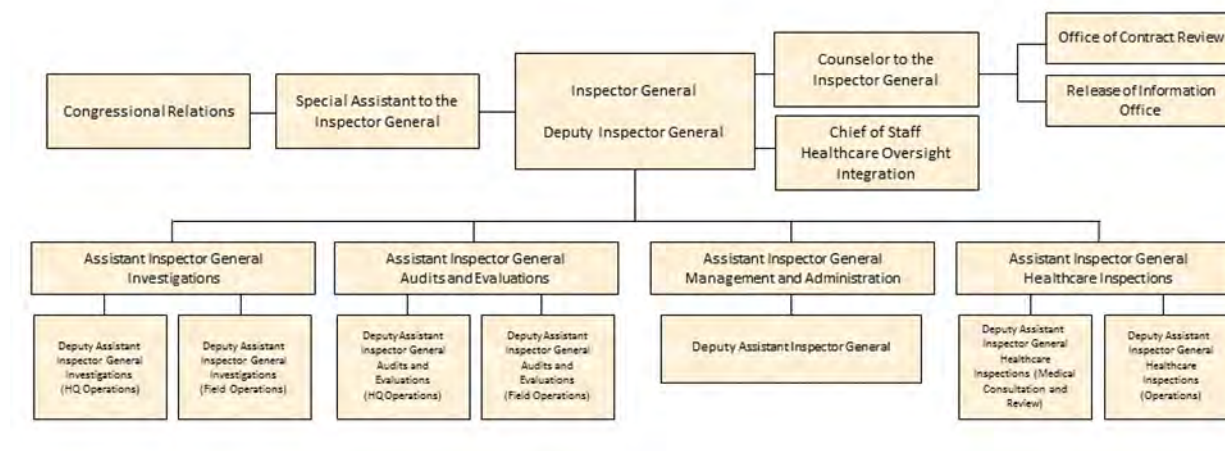


Figure 3 - Office of the Inspector General

[Click here to go to the alternate representation](#)

Office of Inspector General

Overview

The Office of Inspector General (OIG) was administratively established on January 1, 1978, to consolidate audits and investigations into a cohesive, independent organization. In October 1978, the Inspector General Act, P.L. 95-452, was enacted, establishing a statutory Inspector General (IG) in VA. It states that the IG is responsible for: (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The IG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. In addition, P.L. 100-322, passed on May 20, 1988, charged OIG with the oversight of the quality of VA health care. Inherent in every OIG effort are the principles of quality management and a desire to improve the way VA operates by helping it become more customer-driven and results-oriented.

OIG, with 690 employees from appropriations, is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. FY 2016 funding for OIG operations provides \$136.8 million from ongoing appropriations. The Office of Contract Review, with 31 employees, received \$5.7 million through a reimbursable agreement with VA for contract review services including pre-award and post-award contract reviews and other pricing reviews of Federal Supply Schedule (FSS), construction, and health care provider contracts. In addition to the Washington, DC headquarters, OIG has field offices located throughout the country. OIG keeps the Secretary and Congress fully and currently informed about issues affecting VA programs and the opportunities for improvement. In doing so, OIG staff strive to be

leaders and innovators, and to perform their duties fairly, honestly, and with the highest professional integrity.

Functions and Activities

- Has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements.
- Receives complaints and allegations of wrongdoing from VA employees, members of Congress, the public, or other stakeholders.
- Performs audits, evaluations, reviews, inspections, and investigations aimed at preventing and detecting criminal activity, waste, abuse, and mismanagement.
- Refers criminal cases to Federal, state, and local authorities for criminal and/or civil prosecution.
- Presents findings and makes recommendations designed to improve the integrity, efficiency, accountability, quality, and effectiveness of VA programs and operations.
- Keeps the Secretary and the Congress fully and currently informed about problems relating to VA programs and operations and the need for corrective action.
- Provides semiannual reports to SECVA and Congress as required by the *Inspector General Act of 1978*, as amended, which are made available to the public on the OIG Internet site.

Authorities

P.L. 95-452

P.L. 100-322

P.L. 100-504

P.L. 110-409

Board of Veterans' Appeals

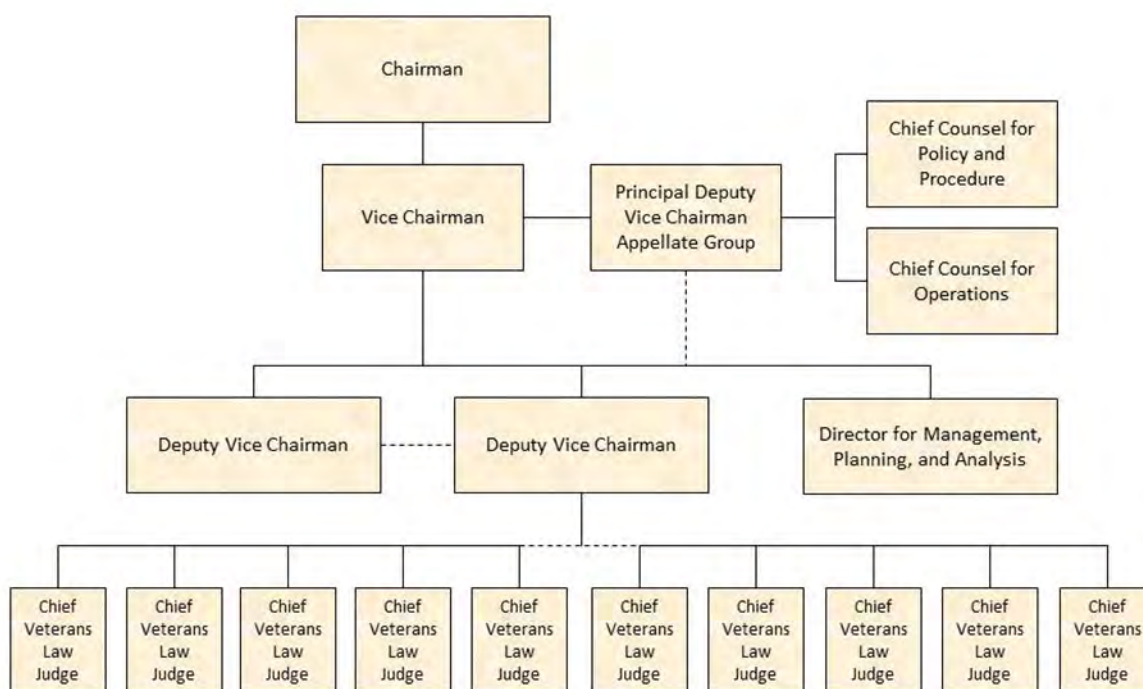


Figure 4 - Board of Veterans' Appeals Organization Chart

[Click here for the alternate representation of the chart](#)

Board of Veterans' Appeals (Board)

Mission

The mission of the Board is to conduct hearings and dispose of appeals properly before the Board in a timely manner.

Overview

The Board was established in 1933 and operates by authority of, and functions pursuant to, Chapter 71 of Title 38, U.S.C. The Board consists of a Chairman, Vice Chairman, Principal Deputy Vice Chairman, and sufficient Veterans Law Judges (VLJ), staff counsel, and other administrative and clerical staff to conduct hearings and decide appeals in a proper and timely manner. The Board's organizational structure includes an Office of the Chairman; the Appellate Group; an Office of Management, Planning and Analysis (MPA); and an Office of VLJs.

The Board has jurisdiction over appeals arising from the Department's regional offices, medical centers, National Cemetery Administration (NCA), and Office of General Counsel (OGC). Although the Board has jurisdiction over a wide variety of issues and matters, the vast majority of appeals considered involve claims for disability compensation or survivor benefits. Examples of other types of claims addressed by the Board include fee-basis medical care, waiver of recovery of overpayments, reimbursements for

emergency medical treatment expenses, education assistance benefits, vocational rehabilitation training, burial benefits, and insurance benefits.

Functions and Activities

- Resolves appeals claims and/or remands issues for further development.
- Conducts Travel Board, Video Teleconference, and Central Office appellate hearings for appellants.

Office of the Chairman/Appellate Group

Overview

The Office of the Chairman consists of a Chairman and a Vice Chairman (Senior Executive Service (SES)/VLJ)). The Chairman is appointed by the President, by and with the advice and consent of the Senate, for a term of 6 years, and is directly responsible to the Secretary. The Vice Chairman is a Member of the Board who is designated by the Secretary. The Board's Appellate Group consists of a Principal Deputy Vice Chairman (SES/VLJ), a Chief Counsel for Policy and Procedure (Senior Level (SL)), and a Chief Counsel for Operations (SL). The Appellate Group provides legal advice and policy guidance to the Board and other VA business lines, and includes the following offices: Litigation Support, Quality Review, the Office of Learning and Knowledge Management (Training Office), Labor and Employee Relations, Regulations Office, Research Center, and a Medical Advisor.

Functions and Activities

Manages the overall operations of the Board:

- Conducts the administrative processing of appeals remanded to the Board from the Federal courts.
- Responds to case status inquiries from Veterans, representatives, and members of Congress.
- Develops Board-wide guidance documents, including Chairman's memoranda and other directives.
- Drafts regulatory amendments and reviews and comments on regulations promulgated by other VA organizations that affect compensation benefits, representation before the Department, and claims and appeals processing.
- Serves as a liaison between the Board and other VA components, as well as external stakeholders, regarding any matters related to the Board.
- Works in close collaboration with the Office of Human Resources and Administration (OHRA) to oversee human resource functions for the Board, to include aggressive hiring of Veterans at all levels of the organization by partnering with VA's Veteran Employment Services Office (VESO).

Establishes and implements Board policies and procedures:

- Manages and runs the Board's Quality Review Program.

- Processes requests for information pursuant to the Freedom of Information Act (FOIA) and the Privacy Act.
- Coordinates training efforts for VLJs and staff counsel, as well as training with other VA offices, as appropriate.
- Maintains legal and medical research materials in various media to assist VLJs and staff counsel in appeals adjudication.
- Provides consultation and training on complex medical questions and provides technical review of medical opinion requests.
- Provides legal guidance to the Board's senior management for employee/labor relations and Equal Employment Opportunity (EEO) matters.
- Recommends charges and penalties in disciplinary matters within the Board.
- Serves as a liaison with Central Office Human Resources Service (COHRS), labor management relations (LMR), and the OGC.
- Recommends resolutions in employee/labor relations and EEO matters and negotiates for the same with employees and their representatives.

Office of Management, Planning and Analysis

Overview

The Office of Management, Planning and Analysis, is the administrative directorate of the Board, consisting of the Director, the Deputy Director, the Administrative Support Division, the Office of VLJs Support Division, and the Financial Management Division. MPA also has a call center based in Wilkes-Barre, Pennsylvania.

Functions and Activities

Provides support to the Office of VLJs.

- Provides logistical and administrative support for the scheduling and conduct of Board hearings.
- Controls the administrative processing of requests for outside medical opinions.
- Manages the storage and flow of cases throughout the Board in close coordination with Board leadership.
- Dispatches Board decisions and provides administrative support to VLJs and staff counsel.

Provides administrative support to the Board and coordinates with other branches of VA to provide timely responses to inquiries from the public.

- Responds to case status and other inquiries from Veterans, their representatives, and other VA offices.

- Processes incoming claims files and establishes appropriate administrative controls.
- Processes incoming mail received at the Board.
- Secures the translation of foreign language documents contained in claims files.
- Provides overall financial management for the Board.
- Develops and executes an annual budget.
- Procures and administers contracts.

Office of VLJs

Overview

The OVLJ consists of two Deputy Vice Chairmen (DVC) (SES/VLJ), 10 Chief VLJs, up to 78 VLJs, and approximately 440 attorneys who prepare tentative written decisions for review and signature by a VLJ. VLJs are appointed by the Secretary, with the approval of the President, based upon recommendations of the Chairman.

Functions and Activities

OVLJ produces timely and accurate appellate decisions for Veterans and other appellants, on appeals from regional offices and other parts of the Department responsible for the initial adjudication of benefit claims.

- Staff counsel reviews the record on appeal, researches the applicable law, and prepares comprehensive draft decisions/remand orders for review by a VLJ.
- VLJs review draft decisions/remand orders prepared by staff counsel and issue final decisions, appropriate preliminary orders, and rulings on motions that arise during the course of the proceedings.
- VLJs preside over hearings in appeals before the Board, which are either held in person at the Board's offices in Washington, DC, at a regional office, or other field facility designated by the Department or by way of video-teleconference; and rule on motions made during the course of such hearings.

Authorities

38 U.S.C. Chapter 71

38 CFR Parts 19 and 20

Office of General Counsel

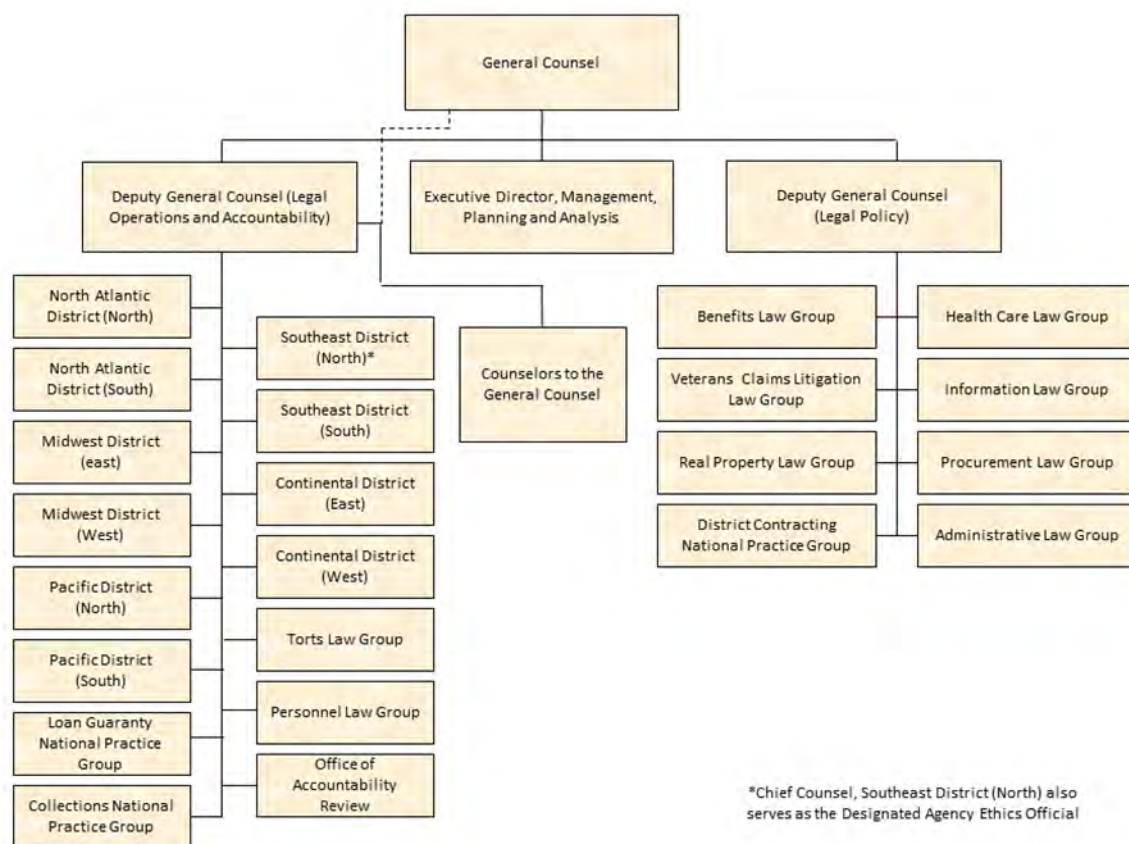


Figure 5 - Office of General Counsel

[Click here for the alternate representation of the chart](#)

Mission

The Office of General Counsel provides legal advice and services to the SECVA and all organizational components of the Department. The General Counsel is, by statute, the Department's Chief Legal Officer.

General Counsel

Overview

The Office of General Counsel (OGC) serves as VA's in-house counsel and is committed to ensuring that every member of OGC is focused on how OGC's work impacts Veterans, and also has an understanding and commitment to the business priorities of our VA clients many of whom directly serve Veterans.

OGC's attorneys act as business partners, providing sound legal expertise, and as needed, critical problem-solving skills and risk-management advice.

Functions and Activities

- OGC strives to provide real-time legal advice. Our goal is to be involved with Department decision-makers (our clients) during the initial phases of decisions and actions, rather than focusing only on defending actions after decisions have been made. This proactive, preventive-law approach promotes better outcomes and reduces risk.
- The General Counsel, Deputy General Counsel for Legal Operations & Accountability, and Deputy General Counsel for Legal Policy advise the Secretary (SECVA), Deputy Secretary (DEPSECVA), VA Chief of Staff (COSVA), and other senior Department officials regarding all laws, regulations, Executive Orders, and judicial precedent pertaining to the Department and its operations.
- OGC provides a full range of legal and litigation services, as well as support for legislative and regulatory activities through our Chief Counsels who lead eight VA Central Office (VACO)-based Law Groups, three National Practice Groups (NPGs), ten Offices of Chief Counsel in the Districts, the Ethics Specialty Team (EST), and the Office of Accountability Review (OAR). Two Counselors to the General Counsel focus on implementing Agency priorities regarding Veteran Experience and Employee Experience within OGC. OGC's internal administrative functions are led by the Executive Director, Management, Planning & Analysis.

Authorities

38 U.S.C. § 311

38 CFR § 14.500 et seq.

Deputy General Counsel (Legal Operations and Accountability)

Overview

The Deputy General Counsel (Legal Operations and Accountability) supervises a team of Senior Executive Chief Counsels responsible for leading two Law Groups at VA Central Office (Personnel Law, and Torts & Administrative Law), ten Offices of Chief Counsel, two for each VA District, two National Practice Groups, virtual nationwide teams focused on Collections, and Loan Guaranty, the Ethics Specialty Team (EST), and the Office of Accountability Review (OAR).

Deputy General Counsel (Legal Policy)

Overview

The Deputy General Counsel (Legal Policy) supervises a team of Senior Executive Chief Counsels responsible for leading seven of OGC's Law Groups (Administrative Law, Benefits Law, Health Care Law, Information Law, Procurement Law, Real Property Law, and Veterans Claims Litigation Group), and the District Contracting National Practice Group, a virtual nationwide team. Law Group attorneys typically possess expertise in specific subject-matter areas and provide legal advice to program officials, review proposed regulations and directives, and handle litigation involving VA programs.

Benefits Law Group

Overview

The Benefits Law Group provides legal advice to the Veterans Benefit Administration (VBA), National Cemetery Administration (NCA) (except Real Property), and with the assistance of the Department of Justice, represents the SECVA in litigation at the U.S. Court of Appeals for the Federal Circuit.

Functions and Activities

- Ensures compliance with laws, regulations, and policies affecting VA benefits and NCA operations, and that VA programs carry out the intended purpose of serving Veterans, and protecting VA from litigation outcomes that are costly or inhibit efficient provision of service to Veterans.
- Ensures timely review, approval, and oversight of the accreditation process which improves Veterans' access to qualified representatives.
- Supports the Department of Justice defense of benefits litigation.

US Court of Appeals for Veterans Claims Litigation Group

Overview

Ensures that there is a legally sound claims process for Veterans to appeal decisions issued by the Board of Veterans Appeals (BVA); defends the SECVA's adjudication of Veterans' claims for compensation and other benefits; ensures court filing deadlines are met, thereby avoiding delays affecting resolution of Veterans' claims.

Functions and Activities

- Provides legal representation for the SECVA regarding appeals from BVA decisions to the U.S. Court of Appeals for Veterans' Claims (CAVC).
- Representation includes legal research, drafting and filing pleadings, and oral argument before the CAVC.

Health Care Law Group

Overview

The Health Care Law Group provides advice to the Veterans Health Administration regarding health care administration and operations, including eligibility for care, homeless programs, Veterans Canteen Service, patents, medical research, and non-profit research corporations.

Functions and Activities

- Ensure compliance with laws and that VA programs fulfill the intended purpose of serving Veterans, while protecting VA from costly litigation or efficient service to the Veteran.

- It assists in clarifying eligibility requirements for community care. Clear guidelines to meet VA's community care needs will improve the Veterans' experience and access to health care.

Information Law Group

Overview

Information Law Group attorneys provide advice regarding Information Disclosure [Freedom of Information Act (FOIA) , Privacy Act, Health Insurance Portability and Accountability Act (HIPAA), Privacy, Information Security, and Breach Notification Rules, Title 38 confidentiality statutes], Electronically Stored Information (ESI) Disclosure, Touhy, Information Security & Technology, Records and Information Management, Data Governance, Federal Advisory Committee Act (closed meeting issues), Copyright & Trademarks, and Legislative Counsel affairs.

Functions and Activities

- Provides subject-matter experts on Information Law, including privacy, disclosure, records and information management, information security and technology.
- Assists with the disclosure of electronically stored information (as ordered by courts or requested by parties as discovery in litigation, ordered by administrative bodies in administrative complaints, requested by congressional committees, directed by the Office of Accountability and Review for internal investigations, requested by law enforcement agencies, directed by the Office of Special Counsel in investigation of retaliation and whistleblower complaints, and requested by the public under FOIA).
- Provides advice on accommodation of Congressional oversight investigations.
- Serves as final arbiters of fact in administrative appeals under the FOIA and Privacy Act.
- Advises agency officials on information security matters, including responding to data breaches involving VA sensitive information.
- Negotiates terms of business associate agreements, data use agreements, and other agreements to safeguard VA data disclosed to other entities pursuant to HIPAA and other release statutes.
- Reviews terms of service and memoranda of understanding with social networking and other service providers to promote and protect VA's online presence.

Personnel Law Group

Overview

The Personnel Law Group provides advice to VA management regarding human resources (Title 5 & 38), labor relations, Equal Employment Opportunity (EEO), Merit Systems Protection Board, Office of Special Counsel (whistleblower retaliation), and immigration matters.

Functions and Activities

- Defends VA, promotes just results, and protects Agency resources. Protects employees by ensuring Agency actions do not violate laws, regulations, and policies which protect whistleblowers; ensuring disciplinary actions are sound, and defending them on appeal, to promote better service to Veterans.
- Develops and coordinates the Department's response to, and provides legal advice regarding Congressional oversight requests and hearings, increases transparency and improves trust in VA, which benefits Veterans.
- Serves as Counsel for the Secretary and VA staff on cases before the Merit Systems Protection Board.
- Provides legal counsel for labor relations matters including representing VA during labor union negotiations.
- Provides litigation assistance to the US Department of Justice on major class action litigation before the U.S. Court of Federal Claims and in other cases filed in federal court.
- Provides agency head reviews of all master collective bargaining agreements and local supplemental agreements.
- Provides technical legal review of all 38 U.S.C. § 7422 decision memos.
- Provides subject-matter expertise in all matters involving labor relations, EEO, personnel, and immigration law.
- Drafts precedential, advisory, and informal OGC opinions related to personnel, labor, EEO, and immigration law matters.

Procurement Law Group

Overview

The Procurement Law Group provides guidance regarding Government Supply and Service Contracts, including information technology, Sharing Agreements (38 U.S.C. § 8153), Bid Protest Litigation, post-award contract administration issues and litigation, and Debarment and Suspension.

Functions and Activities

- Partners with VA offices to secure legally compliant contracts which strike the best bargain for Veterans.
- Serves as Counsel for the Secretary and VA staff on cases before the Civilian Contract Appeals Board, Government Accountability Office, and U.S. Court of Federal Claims.
- Defends VA and prepares VA responses in all litigation related to agency contracts.

Real Property Law Group

Overview

Serves as full-service in-house and litigation counsel for Real Property matters (e.g., land acquisitions & disposals, medical facility leases, enhanced-use leases, easements, permits, and licenses); Personal Property matters (e.g., modular buildings, wheelchairs), Environmental Law; Energy & Utility Matters; Construction Matters; and Architect-Engineer Matters.

Functions and Activities

- Provides pre-award and post-award legal support for solicitations and contracts including participants on Integrated Product Teams and Contract Review Boards.
- Provides Transaction and Litigation support & assistance.
- Provides “first chair” legal services for matters filed at the Civilian Board of Contract Appeals, and the Government Accountability Office.
- Provides “second chair” legal services in support of the U.S. Department of Justice, for matters filed at the Court of Federal Claims, and in Federal District Court.
- Reviews Legislative, testimony, VA budget questions, and regulations.

Torts and Administrative Law Group

Overview

The Torts and Administrative Law Group provides advice and legal services regarding Torts, Bankruptcy, Federal Advisory Committee Act (FACA), Administrative Procedures Act (APA), Appropriations, Personal Immunity & Department of Justice (DOJ) Representation, Law Enforcement, and Gifts to VA. The Torts functions fall within the oversight of the Deputy General Counsel (Legal Operations & Accountability), while the Administrative Law functions fall under the Deputy General Counsel (Legal Policy).

Functions and Activities

- Reconsiders denied tort claims from OGC District Chief Counsel (DCC) Offices, and negotiates claims transferred for settlement above DCC authority; monitors tort claim litigation in United States District Courts. Requests representation for Department officials who are sued in their individual capacity.
- Reviews appropriation requests to Congress and advises VA senior leaders concerning the use of congressionally-appropriated funds.
- Renders advice on law enforcement matters, such as offenses on VA property, officer jurisdiction and authority, and cooperative agreements with local, state, and Federal law enforcement authorities.

Management, Planning and Analysis

Overview

OGC's internal administrative functions are led by the Executive Director, Management, Planning & Analysis (MPA).

Functions and Activities

- Manages Client Communications, Budget Division, Knowledge Management (KM), OGC National Training Office, OGC Human Resource Services, FOIA Officer, the Records Management Officer, the Privacy Officer, and the Law Library.
- Maintains the OGC SharePoint site and client website; assists the National Training Office in presenting, recording, and maintaining recordings of national training offerings; and otherwise supports various KM activities throughout OGC.
- Plans, prepares, and presents training offerings of interest to OGC employees. The NTO also catalogues listings of core competencies required for OGC personnel to perform their assigned duties; surveys employees and their supervisors to determine current core competency levels and core competency gaps, if any, that may need to be addressed through training or professional development.
- Adjudicates initial requests for OGC records under FOIA, Title 5 U.S.C., Section 552. All agencies of the Executive Branch of the United States Government are required to disclose records upon receiving a written request for them, except for those records (or portions of them) that are protected from disclosure by the nine exemptions and three exclusions of the FOIA. OGC has one FOIA Officer at VACO to whom all FOIAs that are submitted to OGC Offices throughout the United States are sent for processing.
- Maintains a Law Library that contains legal reference material, including managing OGC's automated legal research contracts and an archival collection of OGC letters and opinions from the 1920s to present.
- Provides planning and analysis services, including Strategic Planning, Client & Legal Priorities, Client Satisfaction, OGC Performance, and Reports Analysis Planning & Statistics.

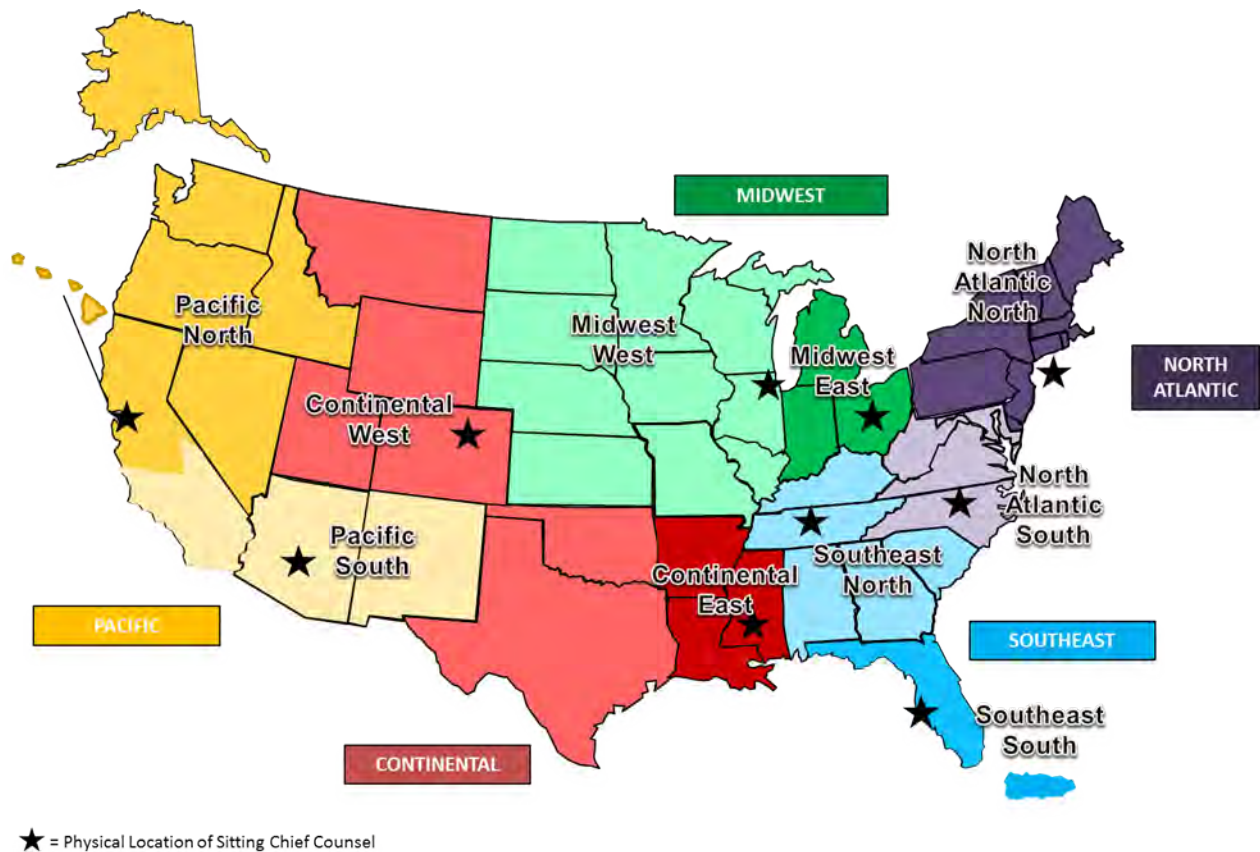


Figure 6 - Map of States Within VA Districts

[Click here for the alternate representation of the chart](#)

Offices of Chief Counsel in the Districts

Overview

There are two Chief Counsel Offices in each VA District; each office is led by a senior executive Chief Counsel. Each Chief Counsel is responsible for providing legal advice and assistance to Directors and other officials at all VA facilities within their jurisdiction.

Functions and Activities

- Advises and represents management of VA facilities on issues relating to personnel and labor law.
- Performs legal review of administrative tort claims and provide legal support to the local U.S. Attorneys' Offices in tort litigation.
- Provides other legal services and consultation as needed.

NATIONAL PRACTICE GROUPS

Overview

OGC's National Practice Groups (NPG) provide consolidated legal services to clients in a specific practice area. Clients with needs in these areas contact the applicable NPG directly for legal services.

Functions and Activities

- District Contracting National Practice Group – Provides legal advice, reviews, litigation representation, and support on matters pertaining to VA contracts, sharing agreements, and leases conducted by District contracting activities outside of the Office of Acquisition Operations.
- Collections National Practice Group - Recovers funds owed to the United States by various legal-collection remedies, to include litigation in Federal and State courts.
- Loan Guaranty National Practice Group - Provides necessary legal services in connection with the activities of VBA's Loan Guaranty Program.

Ethics Specialty Team

Overview

OGC's Ethics Specialty Team (EST) manages the Department's Ethics Program, assisting VA employees in complying with the Standards of Ethical Conduct for Employees of the Executive Branch, criminal statutes related to conflicts of interest, and other laws governing employee conduct. The Chief Counsel, Southeast District North, also serves as VA's Designated Agency Ethics Official (DAEO) and leads the EST. Clients contact the EST directly for advice on ethics issues.

Functions and Activities

- Oversees VA's Financial Disclosure Program: Information on the types of financial disclosure reports (Public (OGE Form 278 and OGE Form 278-T) and Confidential (OGE Form 450)), who must file, when, and with which forms. Also includes information about the STOCK Act and VA's list of positions required to file a confidential report.
- Conflicts of Interest and Impartiality: Provides Information regarding avoiding criminal conflict of interest violations and the appearance of partiality.
- Fundraising: Rules regarding Federal employee fundraising.
- Gifts: Information regarding Gifts From Outside Sources, Gifts Between Employees, Gifts to VA, Awards from Outside Organizations, free attendance at widely attended gatherings, and Gifts from Foreign Entities.
- Donated Travel: When an employee travels on official duty and a non-Federal entity pays for all or part of the travel, this is a gift to VA which must be approved by the appropriate officials through VA Form 0893.

- [Misuse of Government Resources](#): Information on misuse of Government resources such as property, time, non-public information, and position. This also includes information regarding endorsement and governmental sanction.
- [Outside Activities](#): Information on personal activities outside of VA position.
- [Political Activities](#): Information regarding the Hatch Act, which governs the political activities of Federal employees.
- [Seeking Employment and Post-Government Employment Restrictions](#): Information for employees who are seeking, or who have an arrangement for, non-Federal employment.
- [Representation of Others before Federal Agencies or Courts](#): Information regarding the circumstances under which Federal employees are prohibited from representing others before a Federal agency or court.

Office of Accountability Review

Overview

The Office of Accountability Review was chartered to expedite the Department's leadership accountability reset. In addition to addressing senior leader accountability for scheduling and access improprieties, OAR reviews and investigates allegations of misconduct and lack of oversight by senior leaders throughout the Department and further ensures leadership accountability actions are applied consistently across the Department.

Functions and Activities

- Ensures timely and thorough investigation of complaints regarding VA senior managers to promote better service to Veterans.

Counselors to the General Counsel

Overview

OGC's Counselors to the General Counsel (CGC) serve as senior legal advisors to the General Counsel on any and all matters directed to them for consideration and/or action. In light of OGC's recent re-organization in accordance with the Secretary's MyVA initiative, the CGCs have an important role in facilitating the smooth and seamless transition to OGC's new organization model. In addition, the CGCs have been tasked to address and focus their expertise and years of experience on one or more of the five major tenets of MyVA (improving the veteran experience, improving the employee experience, achieving support services excellence, establishing a culture of continuous performance improvement, and enhancing strategic partnerships).

Functions and Activities

- Provides leadership to address some of OGC's longstanding strategic challenges that simply do not get "fixed" because of business each day.

- Implements recommendations made by OGC advisory committees and approved by the General Counsel.
- Serves as leaders within OGC dedicated to increasing awareness about, and implementing changes to programs, policies, and operations to enhance organizational focus on, keeping Veterans in mind when conducting OGC business, and incorporating employee-centric matters such as engagement, leadership development, client satisfaction, diversity, and employee fact finding, into daily supervisory activity.

Office of Acquisition, Logistics, and Construction

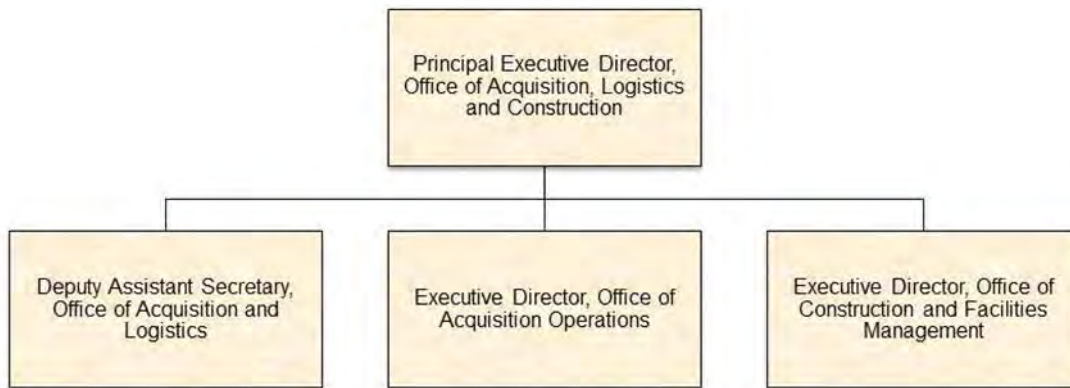


Figure 7 - Office of Acquisition, Logistics and Construction Organization Chart

[Click here for the alternate representation of the chart](#)

Office of the Principal Executive Director

Overview

Provide a full range of innovative, cost-effective business solutions, and responsible services tailored to meet the ongoing and emerging needs of our customers in their support of America's Veterans and their families. For more information, please visit <http://www.va.gov/oalc/>.

Functions and Activities

Establishes and oversees enterprise acquisition policy, processes, and education. Also serves as Chairman of the VA Acquisition Executive Council.

- Serves as the primary advisor to the DEPSECVA on acquisition-related items.
- Develops and maintains the acquisition career management program. Trains and certifies the entire acquisition team through the operation of the VA Acquisition Academy.
- Manages and establishes standards for VA's enterprise wide acquisition technology tools.
- Formulates, reviews, and implements enterprise wide acquisition policy, ensuring compliance with Federal acquisition policy promulgated by Office of Federal Procurement Policy, legislation, and other regulatory entities.
- Develops VA Supply chain management policy and monitors enterprise wide operations.
- Provides strategic direction and management oversight of VA's delegated authority from the General Services Administration (GSA) to establish and maintain Federal Supply Schedules for health care system, commodities, and equipment.

- Establishes performance measures for the agencies acquisition programs.
- Develops and oversees acquisition operations for the Department.
- Serves as the primary advisor to the Deputy Secretary on acquisition operation related items.
- Oversees the formulation of plans and acquisition strategies.
- Ensures the provision of acquisition services to the Department. Serves as Chairman of the VA Supply Fund Board.

Develops and oversees VA's major construction program and leasing activities.

- Serves as the primary advisor to the Deputy Secretary on construction and lease-related items.
- Manages the progress of specific construction and lease projects.
- Promulgates VA's construction, leasing, and historic and environmental preservation policies and standards.
- Reviews, presents and defends the requested budget for VA's major construction and leasing program.
- Oversees the formulation of plans and acquisition strategies for the procurement of land, and construction and leasing services.
- Provides management and oversight of facility engineering operations for strategic capital investment and project prioritization.
- Establishes and implements enterprise wide processes and tools to support and standardize the construction and leasing process.

Authorities

Acquisition Reform Act of 2003 (SARA)

P.L. 93-400, as amended by P.L. 96-83

38 U.S.C. Part VI Chapter 81 Subchapter 1 §§ 8101-8119

Office of the Deputy Assistant Secretary for Acquisition and Logistics

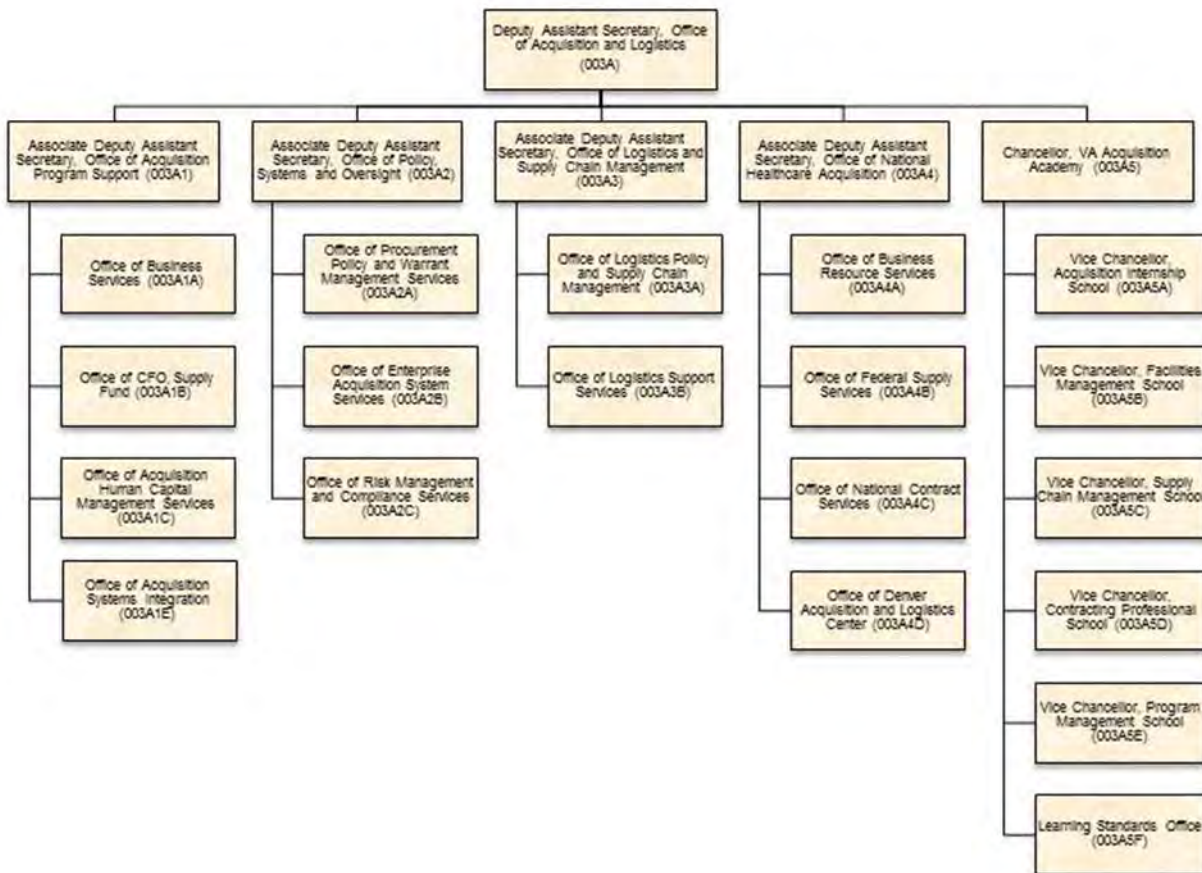


Figure 8 - Office of Acquisition and Logistics

[Click here for the alternate representation of the chart](#)

Overview

Provide acquisition and logistics solutions to meet the needs of our customers in support of America's Veterans and their families. For more information, please visit <http://www.va.gov/oal/>.

Functions and Activities

Responsible for the Department's acquisition and logistics policy development and enforcement functions:

- Serves as the Senior Procurement Executive (SPE) for the Department.
- Serves as the primary advisor to the Chief Acquisition Officer (CAO) and the SECVA on all matters related to acquisition and logistics, and assists the CAO in the planning and execution of enterprise business strategies and acquisition management.
- Establishes and manages all acquisition workforce policies and programs in the Department.

- Oversees acquisition management functions.
- Testifies before Congress on acquisition and logistics activities.
- Directs the full range of programmatic and oversight duties associated with acquisition and logistics policies and procedures, including procurement policies and procedures for the Department.
- Operates a variety of risk management, quality assurance, and compliance programs, and the contracting officer warrant program to ensure proper stewardship of Department resources.
- Oversees the development, deployment, and operational assessment of directives to effectively and efficiently implement Federal law, Presidential Executive Orders, and the Federal Acquisition Regulation (FAR).
- Develops and maintains VA's Acquisition Regulations (VAAR) and other Departmental acquisition and logistics guidance.

Represents the Department in matters pertaining to intergovernmental acquisition and logistics, policies and procedures, and coordinates intergovernmental support operations. Manages the Department's acquisition systems.

- Oversees the operation of enterprise acquisition management information systems and ensures timely and accurate acquisition reporting to the OMB and Congress.
- Provides operational performance assessments related to system use.
- Oversees implementation of system enhancements.
- Oversees acquisition support programs and processes.
- Establishes and manages all acquisition workforce policies and programs in the Department.
- Establishes and manages all acquisition workforce development policies and programs, and manages the Federal acquisition workforce certification programs.
- Develops and deploys Department-level acquisition career management doctrine, policy and implementing regulations to ensure compatibility with overall VA objectives and Federal mandates.
- Directs the strategic planning, operational improvement and integrated performance management functions.
- Formulates, manages, and executes the VA Supply Fund, which supports spending across the Department in the excess of 19B annually,
- Directs the development of metrics and performance standards for all acquisition activities identifying potential systemic problems and/or continuous improvement opportunities.

- Identifies and applies new approaches and/or solutions to improve acquisition planning, execution, and workforce development.

Oversees supply chain management activities.

- Formulates VA-wide logistics and supply chain management doctrine, policy, and strategies for supplier relationship transformation, supply chain process improvement, strategic sourcing and product standardization.
- Ensures VA's logistics and supply chain management program complies with Federal law and regulation, presidential directives, and OMB mandates.
- Oversees a comprehensive review process to ensure VA's logistics programs are organized to achieve cost-effective solutions consistent with laws and regulations, sound business practices, and customer service expectations.

Establishes educational and training requirements and programs for the Department's acquisition workforce:

- Provides training and professional development curriculums based on acquisition workforce competency and certifications requirements established by OMB.
- Oversees the design, development, and management of the Federal Acquisition Certification in Contracting (FAC-C), Program and Project Management (FAC-P/PM), and Contracting Officer's Representatives (FAC-COR) training curriculum practices, procedures and protocols.
- Oversees curriculum development and training delivery of the Schools for Logistics Management and Construction and Facilities Management.
- Develops automated systems to collect and store acquisition workforce data to support VA's acquisition workforce certification program.

Supports VA's health care procurement requirements as well as the needs of other Government agencies:

- Develops and administers healthcare related Federal Supply Schedules and national standardization contracts for health care system, commodities, equipment, services, and just-in-time distribution programs.
- Manages the awards of high volume contracts for recurring items used throughout the Federal health care system.

Authorities

Acquisition Reform Act of 2003 (SARA)

Office of Acquisition Program Support

Overview

The Office of Acquisition Program Support provides the full range of mission support services and operations for efforts focused on Acquisition Workforce Professional Development and Credentialing, VA Supply Fund Management, Human Resources Liaison requirements, Business Transformation, OAL Facilities and Emergency Preparedness.

Functions and Activities

- Manages a comprehensive acquisition career management program in accordance with Office of Management and Budget (OMB) and Office of Federal Procurement Policy (OFPP) Federal Acquisition Certification directives in the areas of Contracting (FAC-C), Contracting Officer Representatives, (FAC-COR), and Program and Project Management (FAC-P/PM).
- Develops and manages an acquisition corps training and certification program for the Department to develop a professional acquisition workforce.
- Develops and manages the Department's "Critical Acquisition Position (CAP)" and "Key Management Position (KMP)" lists to support the development of highly qualified and certified acquisition professionals for assignment to critical programs and contract support positions.
- Develops policy and standards for the Applied Learning Center, analyzes results of competency assessments, and supports development of education and training programs to address acquisition workforce competency deficiencies. Works in close collaboration with the Chancellor of the VA Acquisition Academy to ensure that the Academy offerings are fully synchronized with acquisition workforce needs.
- Develops and maintains acquisition enterprise-level automated business systems requirements that support acquisition workforce management functions, including competency testing, records management, and reporting. Ensures acquisition stakeholder communities are knowledgeable in the use of these systems, develops operational performance assessments related to system use, and implements continuous process improvements.
- Develops, monitors, and supports succession planning for the acquisition workforce across the Department. Prepares an annual congressional report detailing the status of the Department's acquisition workforce.

Office of Business Services

Overview

Manages Business Services functions comprising two divisions: Human Resources Liaison (HRL) and Operations Support (OS).

Functions and Activities

- Responsible for providing an array of human resources services including advice, guidance, and processing, in conjunction with the Central Office Human Resources Services (COHRS), of staffing, recruitment, classification, position management, benefits, employee/labor relations,

performance management, award recognition, Equal Employment Opportunity issues, privacy issues, and actions to support the management and employees of the OAL organization.

- Coordinates with the appropriate offices to include the COHRS, the Office of Resolution Management, and the Privacy Office to complete the processing of human resources actions and resolve issues to ensure applicable laws, rules, regulations and policies are followed.
- Oversees a variety of operational and administrative support programs necessary to sustain business lines in the Office of Acquisition and Logistics (OAL) and the Office of Acquisition Operations (OAO).
- Responsible for facility and workspace planning management systems; learning programs and the Talent Management System (TMS); travel management and the Federal Traveler program; internal procurement and the Government Purchase Card program; transit benefit management system; property management and equipment inventory; several components of EEO; emergency preparedness and Continuity of Operations (COOP) programs; organizational-wide employee training, education, and professional development; and intra-organizational procurement support. Coordinates with a number of offices, including VA Office of Management, General Services Administration, VA Operations and Security Preparedness, VA Office of Resolution Management, VA Construction and Facility Management, VA General Counsel, and the VA Office of Information and Technology.
- Administers, staffs, and manages OALC's Emergency Preparedness program which includes program officials and Watch Officers that provide coverage in the Integrated Operations Center (IOC), with 24/7 capability for monitoring all VA operations at VA Central Office, Washington, D.C. and nationwide. Manages the Emergency Relocation Group (ERG), Devolution ERG (DERG), and Reconstitution ERG (RERG) that serve as the organization's first responders for emergency support and disaster planning, and response and recovery operations.
- Publishes and maintains an Emergency Management Master plan outlining OALC emergency planning and support operations including COOP, disaster recovery, devolution operations, and related media that outlines the actions to be taken to ensure the continuation of OALC's Mission Essential Functions (MEFs), should the VA Central Office ever become unavailable or unsafe to conduct normal operations.
- Provides advice and assistance to ad hoc groups of VA emergency preparedness planners and analysts, and conducts and serves on special committees that address emergency preparedness subjects, logistical resources, emergency and contingency planning and related disciplines. OS supports all VA fourth mission functions required under the National Response Framework (NRF) Emergency Support Functions (ESF) in support of federal, state, local, tribal government, and non-governmental entities. OS monitors (jointly with Watch Officers) domestic and world situations, status of the VA IOC, COOP sites, and all VA components and subcomponents on the national, regional, and local levels.
- Provides around-the-clock acquisition and logistics policy support to the Department via the VA Integrated Operations Center.

Office of CFO, VA Supply Fund

Overview

Manages VA's Supply Fund (Revolving Fund).

Functions and Activities

- Formulates the budget and executes the VA Supply Fund that generates in excess of \$18 billion in annual sales, provides over 1,000 full-time equivalent positions throughout the Office of Acquisition and Logistics (OAL), Office of Acquisition Operations, the Office of Small and Disadvantaged Business Utilization, the Veterans Health Administration's Procurement and Logistics Office, and various legal, assessment, and administrative support positions throughout the Department.
- The Supply Fund recovers its operating expenses through surcharges on various products or services provided to Veterans and other Government agencies (OGA). VA organizations and facilities can use the 1 VA+ Program to extend obligation authority of appropriated funds for short periods of time to support bona fide program needs.
- The Supply Fund supports the Capital Leasing Program to rent equipment, and reduces initial acquisition costs by spreading payments over a period of up to five years. VA and OGA customers routinely take advantage of minimal finance rates offered by the program.
- In partnership with the Finance Service Center in Austin, Texas, the Supply Fund recovers duplicate payments to vendors and unused credits from vendors.
- The Office performs a full range of accounting functions, including recording obligations and processing payments, maintaining financial records of the Supply Fund, performing financial analyses, and managing the annual fund audit process conducted by a private sector accounting firm.

Office of Acquisition Human Capital Management Services (AHCMS)

Overview

Operates under the direction of VA's Departmental Acquisition Career Manager (ACM), who also serves as the Director, Acquisition Human Capital Management Services, advises and assists VA's Chief Acquisition Officer (CAO) and senior leadership in fulfilling and managing VA's acquisition workforce's professional development.

Functions and Activities

- Provides policy development and management of VA's Federal Acquisition Certification (FAC) – Contracting (FAC-C), Program and Project Manager (FAC-P/PM), and Contracting Officer's Representative (FAC-COR) certification programs.
- Assesses and analyzes VA's acquisition workforce competency and certifications requirements and provides acquisition leaders, including Chief Acquisition Officer, Senior Procurement Executive, and Heads of Contracting Activity assessment metrics to support the workforce's professional development and future initiatives.

- Through strategic communications, outreach initiatives, collaborative forums, and engagement, keeps the acquisition workforce updated on changing VA and the Office of Federal Procurement Policy's (OFPP) policies, certification requirements, and other acquisition workforce initiatives.
- Develops and maintains reporting mechanisms for critical operational and transformational metrics, and analyzes performance outcomes to identify potential systemic problems and continuous improvement opportunities.
- Provides complete and accurate data for the Department's FAC certification workforce to VA leadership for information, awareness and reporting to Congressional inquiries such as the VA-wide Acquisition Human Capital Workforce Plan which is provided annually to OMB.
- Oversees the implementation, management, and use of the Federal Acquisition Institute (FAI) Training Application System (FAITAS), to support the processing of all VA FAC requests.
- Develops partnerships and engages with external stakeholders, such as OMB, the Office of Federal Procurement Policy (OFPP), the Federal Acquisition Institute (FAI), other civilian agencies and professional organizations to ensure acquisition workforce preparedness, career and professional development, recognition, and exchange best practices.

Authorities

Acquisition Reform Act of 2003 (SARA)

Federal Property and Administrative Services Act of 1949 (as amended)

31 U.S.C. Economy Act (as amended)

GSA FSS Delegation for Selected Federal Supply Classification Groups of 1961 (as amended).

Office of Acquisition Systems Integration

Overview

Manages Acquisition Strategic Planning and Acquisition Systems Integration functions comprising of two divisions: Systems Integration Division (SID) and Business Transformation Division (BTD).

Functions and Activities

- Develops and deploys departmental procurement performance measures to determine operational effectiveness, efficiency, and achievement of objectives. Develops and manages executive dashboards to support timely decision-making on critical OAL work functions.
- Sponsors acquisition strategic studies to identify and implement industry best practices and business processes related to Program Management and the Acquisition Program Management Framework (APMF). Develops policies and procedures to integrate the APMF across the Enterprise by establishing the appropriate links with the other elements of VA's Strategic Management Process (Planning, Programming, Budgeting and Execution (PPBE) & End - to - End Requirements). Establishing program management doctrine and develops program management policies and procedures to standardize proper activities throughout the Department. This includes the multi-phased and multi-team implementation of the APMF.

- Manages an internal acquisition customer satisfaction/outreach program to identify and resolve systemic problems to include necessary changes in customer's Service Level Agreements.
- Manages operation of VA's Acquisition Executive Council (AEC) to act as the governance structure for life-cycle acquisition management. Also plans and coordinates resource reviews with senior management on the operation of the AEC. Oversees the preparation of milestone status reports, briefings, and presentations for internal and external stakeholders.
- Oversees and develops Acquisition Corps training and certification program for the Department to develop a professional acquisition workforce. Collaborates with VA's ACM for successful management and execution of the program.
- Directs, develops, and manages the Department's "Critical Acquisition Position (CAP)" and "Key Management Position (KMP)" lists to support the development of highly qualified and certified acquisition professionals for assignment to critical leadership programs and contract support positions.
- Coordinates with the VA Acquisition Academy (VAAA) to ensure academy program management course offerings are synchronized with the Department's program management doctrine.
- Develops policies and procedures to integrate the Department's overarching acquisition framework and related business management systems.
- Establishes program management doctrine and develops program management policies and procedures to standardize proper activities throughout the Department.
- Assists with resolving acquisition life-cycle management challenges.
- Supports the Department's Chief Acquisition Officer and senior leadership in fulfilling the acquisition program management oversight function of the Department.

Authorities

Acquisition Reform Act of 2003 (SARA), P.L. 108 - 136

Federal Property and Administrative Services Act of 1949 (as amended)

31 U.S.C. Economy Act (as amended)

GSA FSS Delegation for Selected Federal Supply Classification Groups of 1961 (as amended).

Office of Policy, Systems, and Oversight

Overview

The Office of Policy, Systems, and Oversight provides leadership and management to the Department-wide acquisition program, one of the largest within the Federal Government with annual spending exceeding \$18 billion.

Functions and Activities

- Manages and directs the development, deployment, and operational assessment of directives to effectively and efficiently implement Federal law, Presidential Executive Orders, the FAR and other Department guidance across the acquisition enterprise.
- Formulates, reviews, and implements Department-level acquisition policy and guidance as it relates to the Department's acquisition activities.
- Represents the Department in matters pertaining to intergovernmental acquisition, and logistics policies and procedures, coordinates intergovernmental support operations.

Office of Procurement Policy and Warrant Management Service

Overview

The Office of Procurement Policy and Warrant Management Service formulates VA-wide procurement doctrine and policy. For more information, please visit <http://www.va.gov/oal/about/pps.asp>

Functions and Activities

- Formulates, reviews, and implements VA Acquisition Regulations, which supplements the FAR.

Manages the Contracting Officer Warranting Program:

- Coordinates the issuance of warrants through the Departments Senior Procurement Executive.
- Reviews and processes Contracting Officer warrants for the Department.

Office of Enterprise Acquisition System Services

Overview

Directs the development, deployment, and maintenance of enterprise automated systems, including the Electronic Contract Management System.

Functions and Activities

- Develops and maintains acquisition enterprise-level automated business systems.
- Integrates business systems with other corporate systems such as financial management systems and conducts operational performance assessments.

Office of Risk Management and Compliance Service

Overview

Develops and implements procurement and risk management, quality assurance, and compliance activities. For more information, please visit <http://www.va.gov/oal/about/rmc.asp>.

Functions and Activities

- Monitors operational performance to ensure goals and priorities are met and program activities are controlled.
- Collects data to support internal measurement and assessment programs, and prepares reports for the OMB and Congress.
- Manages the OMB Circular A-123 program to assess, monitor, and improve the effectiveness of internal controls associated with VA acquisition activities. As part of A-123 Assessment, conducts contract/order file reviews to assure compliance with Federal and Departmental regulations and policy.
- Manages VA's Suspension and Debarment program.
- Manages VA's Protest, Mistake-in-Bid, and Task/Delivery Order Ombudsman programs.
- Manages VA's Subcontract Compliance Review program.
- Manages the VA Labor Advisor program.
- Manages the VA Contract Performance Assessment Reporting System program.

Authorities

Acquisition Reform Act of 2003 (SARA)
Federal and Departmental Acquisition Regulations OMB Circular A-123
38 U.S.C. 8127(g)

Office of Logistics and Supply Chain Management

Overview

Establishes and oversees enterprise supply chain management policies.

Functions and Activities

- Formulates Department supply chain management doctrine (guiding principles) and policies, ensuring that supply chain functions are integrated effectively and efficiently with other key enterprise management functions. Formulates supplier relationship management and sourcing strategies. Reviews sourcing strategies to ensure they leverage industry capabilities consistent with Veteran service delivery models and Department resources.
- Analyzes Department buying practices to optimize the Department's purchasing power across diverse product and service commodity groups. Develops and monitors key supply chain performance measures to evaluate supply chain effectiveness, minimize risk to VA's critical supply chains operations, and identify supply chain business process improvement opportunities.
- Develops solutions to mitigate both operational (short-term) and strategic (long-term) gaps in VA supply chain capabilities. Ensures that Department policies comply with all Federal statutes,

regulations and mandates while providing maximum operational flexibility to achieve mission outcomes.

- Represents the Department at various Federal strategic leadership forums such as the Office of Federal Procurement Policy sponsored Government-wide Category Management Leadership Council. Serves as a principal advisor to various internal Department management councils such as the Acquisition Executive Council and the Senior Procurement Council.
- Executes specified operational enterprise logistics support activities including but not limited to: freight management; employee household goods moves; small package express delivery services; publications printing, storage and distribution; biomedical equipment repair services; high-tech medical equipment inspection and acceptance; and the procurement, storage and distribution of burial flags to survivors of deceased Veterans.

Office of Logistics Policy and Supply Chain Management Office (OLSCM)

Overview

Establishes and oversees enterprise supply chain management policies.

Functions and Activities

- Formulates, reviews, and implements Department-level supply chain management policies, including strategic sourcing policies.
- Ensures that supply chain functions are integrated with other key enterprise management functions.
- Monitors relations with VA's supplier community.
- Advises business owners and service providers (e.g., OIT) on enterprise logistics information technology requirements.
- Oversees supply chain management standards.
- Coordinates Federal property management inventory reporting.
- Participates in the Department Planning, Programming, and Budgeting system with respect to assigned areas of responsibility.
- Communicates and coordinates with other Government agencies and members of the public, as appropriate, in carrying out assigned functions.

Office of Logistics Support Service (003A3B)

Overview

Provides specified logistics support services.

Functions and Activities

- Develops printing and publication policy and guidance.
- Provides a wide range of publications services to VA customers, including duplication and distribution services, design services, and preparation of detailed specifications for printed material.
- Manages and develops procedures for Departmental freight management, household goods moves and employee relocations, and small-package express delivery.
- Provides selected shipping and product distribution services for VA, such as all VA stocked forms and publications, burial flags, etc.

Authorities

Acquisition Reform Act of 2003 (SARA)

Federal Property and Administrative Services Act of 1949 (as amended)

Federal Management Regulation §§ 102-36, -38, and -39

Federal Property Management Regulation §§ 101-27 and -42

VA Directives and Handbooks 7002/1 and 7348

U.S.C. Title 44

49 U.S.C. § 10721 and 13172

41 CFR 102-117 and 102-117

FAR Subpart 47.104, Government rate tenders under §§ 10721 and 13712 of the ICA U.S. Government Freight Handbook

VA Handbook 7240, Transportation and Traffic Management (May 24, 1996)

VA Acquisition Regulation Part 847, Transportation Information Letter (IL) 001AL-10-01, Guidance for the Distribution and Replenishment of Burial Flags (Nov. 6, 2009)

Office of National Acquisition Center

Overview

NAC is self-sustaining, revenue generating organization for VA's Supply Fund. With a staff of 291 employees, and locations in Hines, Illinois and Golden, Colorado, NAC is responsible for the establishment and administration of various national healthcare-related acquisition and logistics programs, which serve and benefit VA, our Veterans, and other Government agencies.

NAC has over 2,000 active contract vehicles, providing over 1 million line items and choices, with total contract values in excess of \$10 billion annually in place encompassing commodities and services such as pharmaceuticals; medical/surgical supplies and equipment; high-tech medical systems; dental supplies and equipment; prosthetic/orthotic devices; clinical analyzers; telehealth devices; diagnostic test kits and sets; professional and allied health care services; reference labs; just-in-time distribution programs; drug repackaging; patient centered community care; dialysis services; batteries; and hearing aid repairs.

NAC works collaboratively with its customers and stakeholders to design quality, cost-effective acquisition programs and contract vehicles, which meet or exceed the customers' needs. NAC is comprised of four Service elements: Business Resource Service, Federal Supply Schedule Service, and National Contract Service located in Hines, Illinois, and the Denver Acquisition and Logistics Center

located in Golden, Colorado. For more information, please visit www.va.gov/nac, or www.va.gov/oal/about/nac.asp, or send email to nac@va.gov.

Functions and Activities

Provides leadership, direction and operational oversight for its programs, the facility and staff. Develops and oversees national health care-related acquisition programs for VA and other Government agencies.

- Leads as the organization's Head of Contracting Activity and Competition Advocate.
- Develops and administers strategic business plan for the organization.
- Develops and maintains collaborative partnerships through outreach to and involvement of stakeholders, customers, and industry partners.
- Develops and leads a professional acquisition staff.
- Represents VA at various external Federal and Public panels and workgroups such as GSA's Governance Board, GSA Multiple Award Schedule Policy Workgroup, HHS's Committee for Bioterrorism, Federation of American Hospitals, National Equipment Manufacturers Association (NEMA), etc.
- Markets existing acquisition programs to other Federal and non-Federal agencies.
- Builds partnerships and establishes agreements to provide acquisition services to non-VA partners.
- Works with other Federal agencies to dissolve or consolidate competing programs and leverages combined requirements for the benefit of all.
- Provides transparency and effective communications concerning its programs and processes.

Office of Business Resources Service

Overview

The Office of Business Resource Service is responsible for the day-to-day operations of the facility. Also provides facility management contracting for the building and contingency contracting support and assistance to VA, other Federal and state customers responding to natural and man-made disasters. For more information, please visit <http://www.va.gov/oal/about/nacBrs.asp>.

Functions and Activities

- Provides oversight and management of resources, space, budget, travel, training, and policies for the organization.
- Manages data warehouse tool and reporting related to programs, resources, metrics, accuracy, and compliances including NAC's robust Contract Catalog search tool. For more information, please visit <http://www.va.gov/nac/>.

- Responsible for government information related to FOIA, Privacy Act and electronic records management.
- Provides technical reviews of acquisition documents, solicitations, and contracts.
- Provides acquisition support and assistance to VA's Security and Preparedness, Office of Emergency Management, CDC's Strategic National Stockpile Program.

Office of Federal Supply Schedule Services

Overview

Manages and administers GSA-delegated Federal Supply Schedule program encompassing health care-related products and services, which are used by VA, other Government agencies, State Veterans Homes, state/city/local government, and other entities approved by Congress. For more information, please visit: <http://www.fss.va.gov>.

Functions and Activities

- Establishes and administers VA's Federal Supply Schedule Program.
- Responsible for nine Federal Supply Schedules.
- Reviews, negotiates, and awards new contracts daily.
- Administers daily over 1,750 active contracts.
- Issues over 6,000 modification actions annually.
- Trains and educates customers, stakeholders, contractors, and potential suppliers on the FSS programs, requirements, and processes.
- Develops and issues Federal Supply Schedule newsletter.
- Active participants with GSA on policy, procedure and process development and implementation.

Office of National Contract Service

Overview

Responsible for the establishment, award, and administration of national standardization contract vehicles for pharmaceuticals, high tech medical equipment, and other health care-related commodities and services. For more information, please visit <http://www.va.gov/oal/about/nacNcs.asp>.

Functions and Activities

- Collaboratively partners with stakeholders and customers to develop and award cost-effective acquisition vehicles.

- Leverages various customers' requirements to achieve best pricing, terms, and conditions for all users.
- Establishes and awards national contract, national blanket agreements against the FSS and blanket ordering agreements with AbilityOne firms in support of VA, and other Federal agencies.
- Awards and administers prime vendor distribution (just-in-time) programs for pharmaceuticals and subsistence.
- Partners with DoD, Department of Health and Human Services (HHS), Bureau of Prisons, and other Federal customers on joint procurements of medical/surgical supplies, high-tech medical systems, and pharmaceuticals.

Office of Denver Acquisition and Logistics Center

Overview

This office provides acquisition and logistics support primarily to VHA and our Veterans through the award, administration and delivery of prosthetic/orthotic products and services. For more information, please visit <http://www.va.gov/oal/about/dalc.asp>.

Functions and Activities

- Awards and administers contracts for prosthetic, orthotic, and other medical devices (hearing aids, assistive listening devices, orthotic items, Telehealth devices).
- Provides hearing aid repair services to our Veteran population.
- Awards and administers various healthcare related service contracts such as patient centered community care services, non-VA dialysis services, traumatic brain injury study, and VAAA training courses.
- Provides logistical support in the ordering and delivery of hearing aids, hearing aid batteries, and home telehealth devices to our Veterans and VA facilities.

Authorities

Federal Acquisition Regulation (FAR)

GSA Acquisition Manual

Defense Federal Acquisition Regulations (DFAR)

Federal Property Management Regulations (FPMR)

Acquisition Reform Act of 2003 (SARA)

Federal Acquisition Streamlining Act of 1995 (FASA)

Federal Acquisition Reform Act of 1996 (FARA)

Economy Act, DoD Sharing Agreement 2121, 2111

Federal Property and Administrative Services Act 1949 (as amended)

31 U.S.C.

P.L. 93-400, as amended by P.L. 96-83

GSA FSS Delegation for Selected Federal Supply Classification Groups 1960-Present (as amended)

VA Directives and Handbooks 7124, 7125 and 7126

VA Acquisition Academy

Overview

Provides learning opportunities to prepare, enable, and inspire a competent, certified (where applicable), qualified, and higher performing workforce for an acquisition function which delivers timely, best value solutions to serve Veterans and their families. The VAAA is located in Frederick, Maryland. For more information, please visit <http://www.acquisitionacademy.va.gov>.

Functions and Activities

Oversees all VAAA schools and Office of Enterprise Shared Services:

- Leads and coordinates development and execution of overall VAAA Strategy, aligned with the VA mission.
- Operates the VAAA Planning, Programming, Budgeting, and Execution process for VAAA enterprise.
- Obtains appropriate levels of funding, personnel, and physical resources.
- Performs contract portfolio management, financial management, administration, and oversight.
- Aligns talent development progression with acquisition career progression, professional certifications, and projected workforce needs.
- Works in close collaboration with the Office of Acquisition Program Support to ensure that the VAAA offerings are fully synchronized with current and emerging acquisition workforce needs.
- Oversees VAAA enterprise customer service, customer satisfaction, and mission impact assessment and improvement.
- Builds and maintains strategic collaborative stakeholder partnerships with counterparts across OALC and OAL with OHRA and OPP, and with other Government agencies including Office of Management and Budget (OMB), Office of Federal Procurement Policy (OFPP), OMB Office of Personnel Management (OPM), General Services Administration (GSA), and Federal Acquisition Institute (FAI).
- Provides program management office resources and services for VAAA enterprise.
- Leads VAAA enterprise organizational change and strategic communications efforts.
- Oversees all VAAA public affairs and communication activities.
- Coordinates correspondence management for VAAA enterprise.

Acquisition Internship School (AIS)

Overview

Develops and delivers learning solutions for specially selected cohorts within the contracting component of the acquisition workforce, to prepare, enable, and inspire, competent, certified, qualified, and higher performing acquisition professionals, to provide timely, best value solutions to serve Veterans and their families.

Functions and Activities

- Engages stakeholders to manage stakeholder requirements and ensure that learning solutions align with policy, mandates, and acquisition workforce strategy, incorporate best practices and agency-specific case studies, and efficiently meet the mission performance needs of students and the stakeholders they serve.
- Establishes learning solutions strategy and curriculum to address current and emerging requirements, blending academic rigor, best practices, and real-world experiences.
- Develops and refreshes learning solutions to efficiently meet established requirements, incorporating VA-specific case studies where relevant to objectives.
- Delivers learning solutions in accordance with instructional design and VAAA quality standards, including:
 - Warriors to Workforce (W2W) intern program to train and educate wounded Veterans as either a contract specialist or program manager.
 - Targeted learning interventions.
 - Holistic, cohort-based, internship satisfying Federal Acquisition Certification in Contracting (FAC-C) training requirements.
 - Applied acquisition management and leadership skills training.
 - Conducts standardized assessments of learner, instructor, and learning solutions effectiveness in accordance with established VAAA standards and best practices.
 - Builds and maintains collaborative stakeholder partnerships with VHA, NCA, VBA, CFM, OHRA, OPM, educational partners, and VA Acquisition Internship Program / W2W Sponsors, and others.

Facilities Management School

Overview

The Facilities Management School develops and delivers learning solutions for the Facilities Management component of the acquisition workforce to prepare, enable, and inspire competent, qualified, and higher performing acquisition professionals to cost effectively construct, operate, and manage facilities to provide timely, best value solutions to serve Veterans and their families.

Functions and Activities

- Engages stakeholders to manage stakeholder requirements and ensure that learning solutions align with policy, mandates, and acquisition workforce strategy, incorporate best practices, and agency-specific case studies, and efficiently meet the mission performance needs of students and the stakeholders they serve.
- Establishes learning solutions strategy and curriculum to address current and emerging requirements, blending academic rigor, best practices, and real-world experiences.
- Develops and refreshes learning solutions to efficiently meet established requirements, incorporating VA-specific case studies where relevant to objectives.
- Delivers leaning solutions in accordance with instructional design and VAAA quality standards, including:
 - Competency-based facilities management training, compliant with the Federal Buildings Personnel Training Act.
 - Elective opportunities for continuous learning with approved CLPs, relevant to acquisition certifications and professions.
 - Conducts standardized assessments of learner, instructor, and learning solutions effectiveness in accordance with established VAAA standards and best practices.
 - Builds and maintains collaborative stakeholder partnerships with CFM, GSA, OPM, the Facilities Management Governing Board and others.

Supply Chain Management School

Overview

The Supply Chain Management School develops and delivers learning solutions for the Supply Chain Management and Logistics component of the acquisition workforce to prepare, enable, and inspire competent, qualified, and higher performing acquisition professionals to improve supply chain performance and management at all levels to provide timely, best value solutions to serve Veterans and their families.

Functions and Activities

- Engages stakeholders to manage stakeholder requirements and ensure that learning solutions align with policy, mandates, and acquisition workforce strategy, incorporate best practices and agency-specific case studies, and efficiently meet the mission performance needs of students and the stakeholders they serve.
- Establishes learning solutions strategy and curriculum to address current and emerging requirements, blending academic rigor, best practices, and real-world experiences.
- Develops and refreshes learning solutions to efficiently meet established requirements, incorporating VA-specific case studies where relevant to objectives.

- Delivers learning solutions in accordance with instruction, design and VAAA quality standards, including:
 - Competency-based Supply Chain Management training.
 - Elective opportunities for continuous learning with approved continuous learning points (CLPs) relevant to acquisition certifications and professions.
 - Conducts standardized assessments of learner, instructor, and learning solutions effectiveness in accordance with established VAAA standards and best practices.
 - Builds and maintains collaborative stakeholder partnerships with OLSCM and others.

Contracting Professional School

Overview

Contracting Professional School develops and delivers learning solutions for the contracting/procurement component of the acquisition workforce to prepare, enable, and inspire competent, certified, qualified, and higher performing acquisition professionals; and to provide timely, best value solutions to serve Veterans and their families.

Functions and Activities

- Engages stakeholders to manage stake holder requirements and ensure that learning solutions align with policy, mandates, and acquisition workforce strategy, incorporate best practices and agency-specific case studies, and efficiently meet the mission performance needs of students and the stakeholders they serve.
- Establishes learning solutions strategy and curriculum to address current and emerging requirements, blending academic rigor, best practices, and real-world experiences.
- Develops and refreshes learning solutions to efficiently meet established requirements, incorporating VA-specific case studies where relevant to objectives.
- Delivers learning solutions in accordance with instructional design and VAAA quality standards, including:
 - Competency-based core curriculum courses satisfying FAC-C training requirements.
 - Competency-based core curriculum cohorts program training satisfying FAC-C training requirements.
 - Applied acquisition management and leadership skills training.
 - Elective opportunities for continuous learning with approved CLPs, relevant to acquisition certifications and professions.
 - Conducts standardized assessments of learner, instructor, and learning solutions effectiveness in accordance with established VAAA standards and best practices.

- Builds and maintains collaborative stakeholder partnerships with OFPP, FAI, and others.

Program Management School

Overview

Program Management School develops and delivers learning solutions for the Project/Program Management (P/PM) and Contracting Officer's Representative (COR) components of the acquisition workforce to prepare, enable, and inspire competent, certified, qualified, and higher performing acquisition professionals to manage projects, programs, and resources to provide timely, best value solutions to serve Veterans and their families.

Functions and Activities

- Engages stakeholders to manage stakeholder requirements and ensure that learning solutions align with policy, mandates, and acquisition workforce strategy, incorporate best practices, and agency-specific case studies, and efficiently meet the mission performance needs of students and the stakeholders they serve.
- Develops and refreshes learning solutions to efficiently meet established requirements, incorporating VA-specific case studies where relevant to objectives.
- Establishes learning solutions strategy and curriculum to address current and emerging requirements, blending academic rigor, best practices, and real-world experiences.
- Represents VAAA at meetings of Acquisition Executive Council, Senior Procurement Council, and other key acquisition and workforce development governing bodies.
- Delivers learning solutions in accordance with instructional design and VAAA quality standards, including:
 - Competency-based, core curriculum courses satisfying Federal Acquisition Certifications for Program/Project Management (FAC-P/PM), Contracting Officer's Representative (FAC-COR) training requirements, and FAC-P/PM Core Plus IT training requirements.
 - Facilitated applied workshops for acquisition teams to address programmatic-specific needs throughout the program life cycle.
 - Performance excellence/interdisciplinary skill development training.
 - Holistic, cohort-based, fellows training satisfying Federal Acquisition Certification in Project/Program Management (FAC-P/PM) training requirements.
 - Assistance in development of student post-training action plans to ensure immediate mission impact, and progress toward establishing a program/project management culture in VA.
 - Applied acquisition management and leadership skills training.

- Elective opportunities for continuous learning with approved CLPs, relevant to acquisition certifications and professions.
- Conducts standardized assessments of learner, instructor, and learning solutions effectiveness in accordance with established VAAA standards and best practices.
- Builds and maintain collaborative stakeholder partnerships with VALU, OIT, VHA, CFM, OFPP, FAI, and others.

Enterprise Shared Services

Overview

The Office of Enterprise Shared Services provides academic, administrative, and logistical support services to the VAAA enterprise to improve overall efficiency and effectiveness in meeting the VAAA and VA missions.

Functions and Activities

- Coordinates collection and reporting of standardized strategic and operational metrics for VAAA enterprise.
- Operates capable and secure facilities and infrastructure.
- Coordinates stakeholder engagement process for requirements management for VAAA enterprise.
- Coordinates annual learning solutions planning process for VAAA enterprise.
- Establishes standardized instructional systems design methodologies/strategies.
- Provides logistical support services to students and schools.
- Provides student registration services.
- Establishes standardized customer service strategies for VAAA enterprise.
- Builds and maintains collaborative stakeholder partnerships with VALU, EAS, OHRA, OIT, and others.
- Coordinates accreditation activities for VAAA enterprise.
- Coordinates stakeholder engagement and targeted marketing/outreach activities.
- Provides administrative support services for human resources, and other VAAA operations.

Authorities

Services Acquisition Reform Act of 2003 (SARA)

Office of Federal Procurement Policy (OFPP) Policy Letter 05-01, Developing and Managing the Acquisition Workforce dated April 15, 2005

OMB Memorandum, The Federal Acquisition Certification in Contracting Program, dated January 20, 2006

OMB Memorandum, Revisions to the Federal Acquisition Certification in Contracting (FAC-c), dated May 7, 2014

OMB Memorandum, The Federal Acquisition Certification for Contracting Officer Technical Representatives, dated Nov. 26, 2007 (FAC-COR)

OMB Memorandum, The Federal Acquisition Certification for Program and Project Managers, dated April 25, 2007 (FAC-P/PM)

OMB Memorandum, Revisions to the Federal Acquisition Certification for Program and Project Managers (FAC-P/PM), dated December 16, 2013

OMB Memorandum, Revisions to the Federal Acquisition Certification for Contracting Representatives (FAC-COR), dated September 11, 2011

P.L. 111-308, The Federal Buildings Personnel Training Act of 2010

Office of the Executive Director of Acquisition Operations

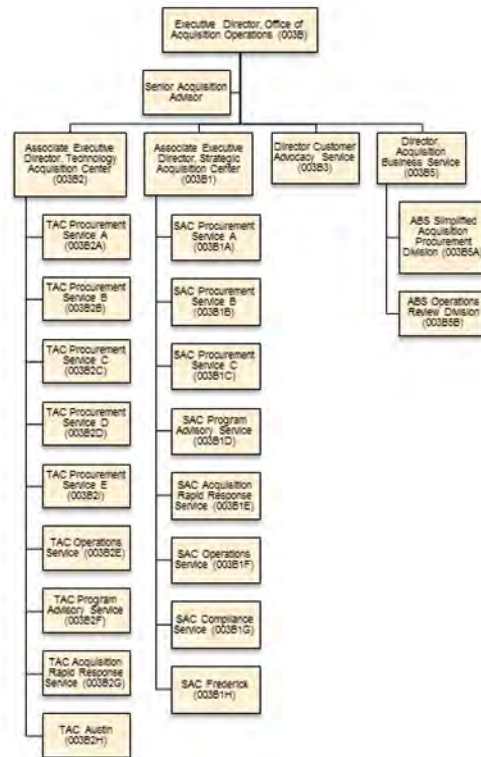


Figure 9 - Office of Acquisition Operations

[Click here for the alternate representation of the chart](#)

Overview

The Office of Acquisition Operations enables our customers to provide best value solutions to Veterans and their families. OAO has support offices in the following locations: Washington, D.C.; Eatontown, New Jersey; Austin, Texas; Fredericksburg, Virginia; and Frederick, Maryland. For more information, please visit <http://www.va.gov/officeofacquisitionoperations>.

Functions and Activities

- Serves as the primary advisor and high-level resource to the Principal Executive Director, OALC on acquisition-related items, and represents the Principal Executive Director in a wide variety of situations with VA, other Federal agencies, and the private sector.
- The OAO Executive Director is one of VA's Heads of Contracting Activity (HCA) that directs acquisition, contracting, and contract administration for the Office of the Secretary, VA Administrations and VACO staff organizations, including OM, H&RA, and OI&T. The HCA

exercises direct-line authority for acquisition actions performed at the Strategic Acquisition Center (SAC), Technology Acquisition Center (TAC), and Acquisition Business Service (ABS).

- Provides execution support of the Department's strategic sourcing programs and initiatives pertaining to information technology (IT) supplies, equipment, and services and non-IT medical supplies, equipment and services, in a manner that increases standardization, reduces cost, and increases transparency in support of the customers' requirements.
- Analyzes procurement data and ensures awarded procurement actions meet and exceed performance measures in accordance with the Department's acquisition program goals and objectives; and directs quality control programs to ensure OAO procurement programs are carried out in accordance with Federal and Department acquisition regulations, authorities, policies, and practices.

Formulates and recommends enterprise wide acquisition operations' guidance, plans, and strategies to leverage VA's buying power in support of the Department's mission, goals, and objectives, and provides advice and guidance to senior leadership in customer organizations.

- Establishes agreements between VA and other Federal and private organizations in an effort to promote economy and effectiveness in the supply process; and is responsible for the procurement management and oversight of VA's interagency agreements and national advisory and assistance contracts for customer organizations.
- Guides and directs development of comprehensive outreach, education, and training programs with OAO customers to ensure quality and timely acquisitions.
- Fosters and maintains positive VA relationships with vendors and supplier community through participation in the administrative, education, community and social events of Federal, state, local, and other affiliated organizations involved with VA programs, VSO, and appropriate civic organizations, and represents VA on intergovernmental groups and councils, and coordinates VA acquisition programs with that of other Government agencies.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)
 Federal Acquisition Reform Act of 1996 (FARA)
 Economy Act, DoD Sharing Agreement 2121, 2111

Strategic Acquisition Center

Overview

The SAC provides highly-complex strategic sourcing and enterprise-wide, non-IT acquisition solutions for the provision of benefits and medical care to the Nation's Veterans. The SAC's offices are located in Fredericksburg, Virginia and Frederick, Maryland.

Functions and Activities

- Develops and oversees enterprise-wide, non-IT acquisition operations and provides direct contracting support to SAC's customer organizations, including VBA, VHA, NCA and HR&A.
- Executes the SAC's Strategic Sourcing Program by overseeing the formulation of plans and acquisition strategies, and accomplishing high-dollar, highly-complex procurements of medical technologies, supplies, equipment, and services identified for strategic sourcing throughout VA.
- Provides advice and assistance to SAC's customer organizations to develop market condition analyses and forecasts, product sources, Government cost estimates, and requirements documents in order to achieve the effective and efficient acquisition of goods and services.
- Provides acquisition support to other Government agencies, and is responsible for executing all non-field, non-IT Interagency Acquisitions/Agreements and Advisory and Assistance contract vehicles.
- Evaluates effectiveness and economy of SAC procurement activities; develops and implements improvement to SAC's business practices, and formulates and recommends acquisition operations guidance, plans, and strategies in support of SAC, OAO and Agency mission, goals and objective.
- Conducts analyses of procurement data to develop acquisition strategies that will leverage the SAC's and VA's buying power, and collaborates with customers to develop appropriate strategies and timelines for all SAC acquisitions.
- Maintains positive relations with industry and supplier community, with the goal of achieving partnerships in support of the SAC's Strategic Sourcing Program.
- Provides comprehensive outreach, education and training to SAC customers and vendors to ensure quality and timely acquisitions, and ensures the SAC's awarded procurement actions meet and exceed performance measures in accordance with the Agency's program goals and objectives, and contract requirements.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)
 Federal Acquisition Reform Act of 1996 (FARA)
 Economy Act, DoD Sharing Agreement 2121, 2111

Strategic Acquisition Center (SAC) Procurement Services A, B, C and SAC-Frederick

Overview

The SAC's Procurement Service Directorates in Fredericksburg, VA and Frederick, MD are responsible for performing cradle to grave support for VA's non-IT acquisitions.

Functions and Activities

- Executes high-dollar, highly-complex procurement of supplies, equipment and services throughout VA.
- Develops and facilitates all pre-award, administration, and post-award procurement actions.
- Prepares appropriate packages and documents for all acquisitions that meet the threshold of the Contract Review Board process.
- Executes non-field Interagency Agreements and Advisory and Assistance Contracts.
- Conducts market research analysis, identifies product sources, establishes partnerships, and maintains positive relationships with customers and vendors in support of VA's mission requirements.
- Provides comprehensive training to customer organizations.
- Collaborates with customers to develop acquisition strategies and timelines for all acquisitions, as appropriate.
- Prepares acquisition packages and correspondence for HCA review and approval.

Authorities

Federal Acquisition Regulation (FAR)

Veterans Affairs Acquisition Regulation (VAAR)

Services Acquisition Reform Act of 2003 (SARA)

P.L. 93-400, as amended by P.L. 96-83

Federal Acquisition Streamlining Act of 1995 (FASA)

Federal Acquisition Reform Act of 1996 (FARA)

Economy Act, DoD Sharing Agreement 2121, 2111

Strategic Acquisition Center (SAC) Program Advisory Service

Overview

The SAC Program Advisory Service (PAS) provides post-award support to VA's program offices for non-IT acquisitions.

Functions and Activities

- Provides cost, schedule, and performance expertise on critical Department programs.
- Coordinates post-award procurement actions.
- Provides comprehensive training to customer organizations.
- Ensures the SAC's awarded procurement actions meet and exceed performance measures in accordance with Agency's acquisition program goals and objectives, and contract requirements.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)
 Federal Acquisition Reform Act of 1996 (FARA)
 Economy Act, DoD Sharing Agreement 2121, 2111

Strategic Acquisition Center (SAC) Acquisition Rapid Response Service**Overview**

The SAC Acquisition Rapid Response Service (ARRS) provides pre-award support to VA's program offices for non-IT acquisitions.

Functions and Activities

- Provides expert advice and acquisition requirement package development services to VA's non-IT program offices.
- Collaborates and coordinates development of pre-acquisition market analyses, market forecasts, product sources, government cost estimates, and applicable requirements documents and justifications.
- Provides comprehensive training to VA program offices.
- Works with SAC's customers to develop acquisition strategies and timelines for all acquisitions as appropriate.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)
 Federal Acquisition Reform Act of 1996 (FARA)
 Economy Act, DoD Sharing Agreement 2121, 2111

Strategic Acquisition Center (SAC) Compliance Service**Overview**

The SAC Compliance Service provides quality control reviews to ensure policy adherence, performance measurements, and risk mitigation for all SAC acquisitions.

Functions and Activities

- Conducts quality control and compliance reviews to assure the OAO acquisition program is managed in accordance with procurement policy, regulations, and generally accepted criteria within the Federal Government.
- Prepares all SAC acquisitions that meet the threshold for Contract Review Board process and utilize Integrated Product Teams.
- Assists contracting staff to ensure electronic and physical procurement files contain required documentation.
- Conducts internal contract performance reviews and audits.
- Collaborates with SAC Program Advisory Service to ensure SAC procurement actions meet and exceed performance measures in accordance with the Agency's program goals and objectives, and contract requirements.
- Prepares procurement data reports for senior acquisition official's analysis and acquisition strategy development to leverage SAC and VA buying power.
- Ensures all SAC acquisitions that meet the threshold undergo a Contract Review Board process and utilize Integrated Product Teams.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)
 Federal Acquisition Reform Act of 1996 (FARA)
 Economy Act, DoD Sharing Agreement 2121, 2111

Technology Acquisition Center

Overview

The TAC provides dedicated acquisition and program management expertise and support for life cycle management of enterprise wide solutions in information and technology (IT), primarily for the Office of Information and Technology (O&IT). The TAC is located in Eatontown, New Jersey and Austin, Texas.

Functions and Activities

- Develops and oversees enterprise-wide IT acquisition operations and provides direct contracting support for TAC's customer organizations, primarily O&IT.
- Executes the TAC's Strategic Sourcing Program by overseeing the formulation of plans and acquisition strategies, and accomplishing high-dollar, highly-complex procurements of IT supplies, equipment and services throughout VA.

- Provides acquisition support to other Government agencies, and is responsible for executing all IT Interagency Acquisitions/Agreements, Advisory and Assistance contracts, and Federally Funded Research and Development Center contract vehicles.
- Provides advice and assistance to TAC's customer organizations to develop market condition analyses and forecasts, product sources, Government cost estimates, and requirements documents in order to achieve the effective and efficient acquisition of goods and services.
- Evaluates effectiveness and economy of TAC procurement activities; develops and implements improvement to TAC's business practices, and formulates and recommends acquisition operations guidance, plans, and strategies in support of TAC, OAO and Agency mission, goals and objectives.
- Conducts analyses of procurement data to develop acquisition strategies that will leverage TAC and VA buying power, and collaborates with TAC customers to develop appropriate strategies and timelines for all IT acquisitions exceeding \$100,000.
- Maintains positive relations with Industry and supplier community, with the goal of achieving partnerships in support of VA's IT acquisition programs.
- Provides comprehensive outreach, education and training to TAC customers and vendors to ensure quality and timely acquisitions, and ensures the TAC's awarded procurement actions meet and exceed performance measures in accordance with the Agency's program goals and objectives, and contract requirements.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)
 Federal Acquisition Reform Act of 1996 (FARA)
 Economy Act, DoD Sharing Agreement 2121, 2111

Technology Acquisition Center (TAC) Procurement Services A, B, C, D, E and TAC-Austin

Overview

The TAC's Procurement Service Directorates in Eatontown, NJ and Austin, TX are responsible for performing cradle to grave support for VA's IT acquisitions.

Functions and Activities

- Executes high-dollar, highly-complex procurement of supplies, equipment and services throughout VA.
- Develops and facilitates all pre-award, administration, and post-award procurement actions.

- Prepares appropriate packages and documents for all acquisitions that meet the threshold of the Contract Review Board process.
- Executes non-field Interagency Agreements and Advisory and Assistance Contracts.
- Conducts market research analysis, identifies product sources, establishes partnerships, and maintains positive relationships with customers and vendors in support of VA's mission requirements.
- Provides comprehensive training to customer organizations.
- Collaborates with customers to develop acquisition strategies and timelines for all acquisitions, as appropriate.
- Prepares acquisition packages and correspondence for HCA review and approval.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)
 Federal Acquisition Reform Act of 1996 (FARA)
 Economy Act, DoD Sharing Agreement 2121, 2111

Technology Acquisition Center (TAC) Program Advisory Service

Overview

The TAC Program Advisory Service (PAS) provides post-award support to VA's program offices for IT acquisitions.

Functions and Activities

- Provides cost, schedule, and performance expertise on critical Department programs.
- Coordinates post-award procurement actions.
- Provides comprehensive training to customer organizations.
- Ensures the TAC's awarded procurement actions meet and exceed performance measures in accordance with Agency's acquisition program goals and objectives, and contract requirements.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)

Federal Acquisition Reform Act of 1996 (FARA)
Economy Act, DoD Sharing Agreement 2121, 2111

Technology Acquisition Center (TAC) Acquisition Rapid Response Service

Overview

The TAC Acquisition Rapid Response Service (ARRS) provides pre-award support to VA's program offices for IT acquisitions.

Functions and Activities

- Provides expert advice and acquisition requirement package development services to VA's IT program offices.
- Collaborates and coordinates development of pre-acquisition market analyses, market forecasts, product sources, government cost estimates, and applicable requirements documents and justifications.
- Provides comprehensive training to VA program offices.
- Works with TAC's customers to develop acquisition strategies and timelines for all acquisitions as appropriate.

Authorities

Federal Acquisition Regulation (FAR)
Veterans Affairs Acquisition Regulation (VAAR)
Services Acquisition Reform Act of 2003 (SARA)
P.L. 93-400, as amended by P.L. 96-83
Federal Acquisition Streamlining Act of 1995 (FASA)
Federal Acquisition Reform Act of 1996 (FARA)
Economy Act, DoD Sharing Agreement 2121, 2111

Customer Advocacy Service

Overview

With its staff of senior acquisition professionals, the OAO Customer Advocacy Service works to resolve acquisition issues for the OAO enterprise. Customer advocates seek to ensure that the customers supported by OAO, our internal staff, vendors, contractors, or other interested parties have a venue to raise concerns and seek assistance when they have questions about the acquisition process.

Functions and Activities

- Serves as expert advisor to customers and acquisition personnel seeking to resolve high visibility or critical impact acquisition-related problems, which have not been resolved through normal or routine corrective actions.

- Provides acquisition support services to customers and becomes involved with pre-acquisition planning for complex, leading edge, challenging procurements to ensure packages correctly reflect the requirements and use innovative approaches.
- Develops and implements comprehensive outreach, education, and training program for OAO customers and vendors to ensure quality and timely acquisitions.
- Advises the OAO Executive Director regarding acquisition strategies and issues, develops and recommends improved business practices for OAO's procurement activities, and coordinates VA's acquisition program in alignment with that of other Government agencies.
- Represents the Executive Director in a wide variety of acquisition situations with VA, other federal agencies, and the private sector.
- Evaluates effectiveness and economy of OAO's procurement activities, and conducts analyses of procurement data to develop acquisition strategies that will leverage VA's buying power, as appropriate.
- Facilitates a program of quality control to assure the OAO acquisition and its associated small business programs meet and exceed performance measures, in accordance with procurement policy, regulations, and generally accepted criteria within the Federal Government.
- Maintains and improves VA relationships through participation in the administrative, education, community, and social events of Federal, State, local and other affiliated organizations involved with VA programs, Veterans Service Organizations, and appropriate civic organizations.

Authorities

Federal Acquisition Regulation (FAR)
 Veterans Affairs Acquisition Regulation (VAAR)
 Services Acquisition Reform Act of 2003 (SARA)
 P.L. 93-400, as amended by P.L. 96-83
 Federal Acquisition Streamlining Act of 1995 (FASA)
 Federal Acquisition Reform Act of 1996 (FARA)
 Economy Act, DoD Sharing Agreement 2121, 2111

Acquisition Business Service

Overview

The OAO Acquisition Business Service (ABS) provides contracting support for the VA Secretary and Central Office staff offices. It also provides acquisition reviews and advice to the OAO Executive Director/HCA for OAO. ABS plays a critical role in the management oversight, guidance, and control for the OAO enterprise.

Functions and Activities

- Formulates and recommends acquisition operations guidance, plans, and strategies in support of VACO staff organizations in alignment with OALC, OAO and Agency mission, goals, and objectives.

- Provides direct contracting support for acquisition actions in support of VACO organizations, including Office of the Secretary, HRA, VBA, NCA, and VHA.
- Serves as primary advisor to the OAO Executive Director regarding acquisition-related items that require the HCA's authority and signature.
- Conducts review and analysis of all unauthorized commitments, unsolicited proposals, and other acquisition-related documents that fall within the authority of the OAO HCA, and facilitates the HCA's approval of the associated procurement actions executed by the TAC, SAC, and ABS.
- Interprets for the Executive Director the implementation of Government wide and agency policies and practices established by regulation or decision of a competent authority.
- Implements and executes a program of quality control and compliance to assure the OAO acquisition program is managed in accordance with procurement policy, regulations, and generally accepted criteria within the Federal Government.
- Develops and implements comprehensive outreach to ABS customers and vendors to ensure quality and timely acquisitions.
- Represents the Executive Director on intergovernmental acquisition matters and coordinates VA's acquisition program with that of other Government agencies.

Authorities

Federal Acquisition Regulation (FAR)

Veterans Affairs Acquisition Regulation (VAAR)

Services Acquisition Reform Act of 2003 (SARA)

P.L. 93-400, as amended by P.L. 96-83

Federal Acquisition Streamlining Act of 1995 (FASA)

Federal Acquisition Reform Act of 1996 (FARA)

Economy Act, DoD Sharing Agreement 2121, 2111

Office of the Executive Director of Construction and Facilities Management

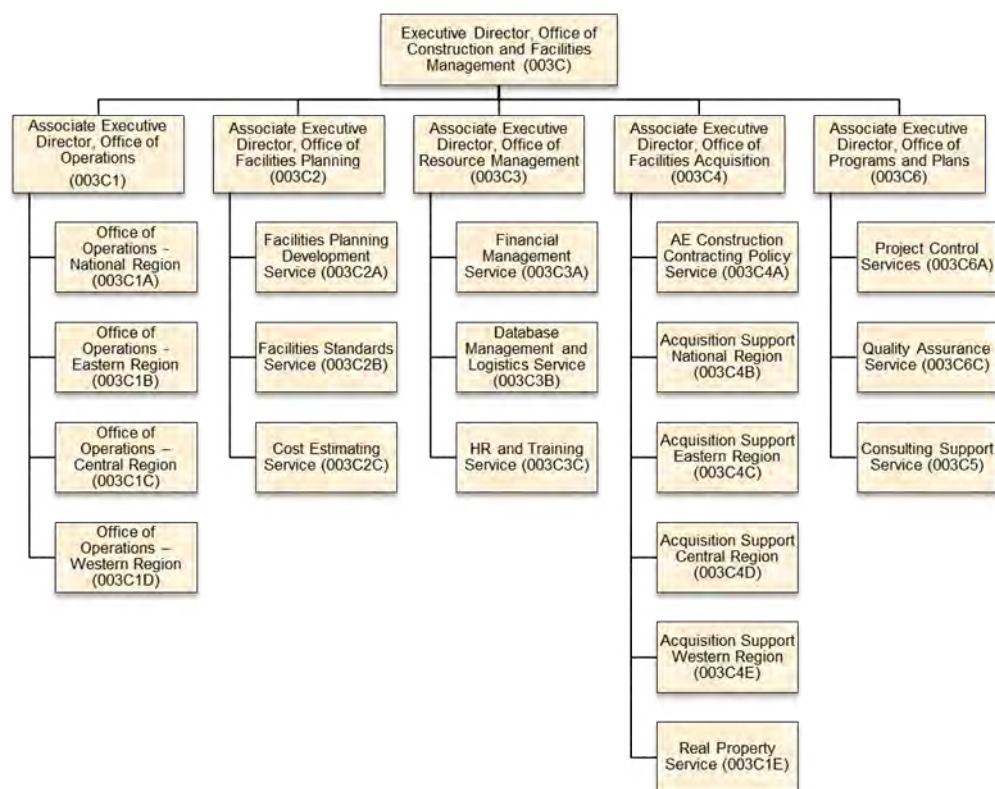


Figure 10 - Office of Construction and Facilities Management Organization Chart

[Click here for the alternate representation of the chart](#)

Overview

The Office of Construction & Facilities Management (CFM) advances VA's mission in support of our Nation's Veterans by planning, designing, constructing, and acquiring major facilities. CFM is responsible for major construction project management ; real property acquisitions, disposals and management; major lease and build-to-suit project management; and design and construction standards for health care facilities. Through its construction and real property programs, CFM delivers to Veterans, high quality buildings, additions, large-scale renovations, and structural enhancements. Additionally, CFM manages facility sustainability, seismic corrections, physical security, and historic preservation of VA facilities, and provides policy and support to departmental officials in these areas.

Functions and Activities

Serves as the primary advisor to the Principal Executive Director, OALC, the DEPSECVA, and the SECVA on all areas pertaining to VA's major construction and real property programs:

- Plans and executes VA major construction, leasing, real property management and other capital asset services in support of VA's mission.

- Supports VA's Administrations and Staff Offices in matters pertaining to policy and quality assurance of VA's capital facilities and real property programs.
- Takes a major role in VA's Strategic Capital Investment Planning process to ensure VA's assets are allocated and implemented in the best interests of the Department and Veterans.

Manages all VA major construction and leasing programs:

- Formulates long-range goals, and develops policies, objectives, priorities, strategies, and procedures to accomplish the responsibilities of the Office of Construction and Facilities Management.

Leads transformation efforts:

- Oversees the development and implementation of an enterprise-level facilities management strategy and performance measures in accordance with established departmental policy.
- Benchmarks with industry leaders to identify state-of-the-art facilities management processes.
- Implements standard facilities management processes across the Department.
- Aligns processes to provide more direct support to customers both regionally and locally.

Authorities

Title 38 Part VI Chapter 81 Subchapter 1 §§ 8101-8119

Acquisition Reform Act of 2003 (SARA)

Office of Operations

Overview

The Office of Operations is responsible for the execution of major construction for VA. It develops and facilitates effective, standard construction management and implementation strategies.

Functions and Activities

- Serves as the primary advisor to the Executive Director of CFM on all matters associated with service delivery to clients and is responsible for facilitating effective and standard construction management and implementation strategies.
- Manages the execution of major construction projects.
- Serves as the Primary Action Officer for emergent high-level issues related to major construction.
- Oversees the design of systems and processes to support CFM's growing construction responsibilities and manages CFM's expansion efforts.
- Fosters collaboration among VA organizations and synthesizes information from various sources to identify best practices to facilitate overall CFM operations.

- Forms relationships with VA facilities leadership, construction, and the Architect/Engineer (A/E) industry to ensure effective execution throughout the country.
- Oversees CFM's regional operations, which implements VHA major construction projects. VACO staff provides support to VBA and NCA in their respective regions.

CFM Regional Offices (Construction)

Overview

Implements and provides technical assistance for the three administrations' major construction projects in their respective regions.

Functions and Activities

Office of Operations - National Region; Office of Operations - Eastern Region; Office of Operations – Central Region; Office of Operations - Western Region;

- Oversees CFM's regional operations, which implements VHA major construction and lease projects. VACO staff provides support to VBA and NCA in their respective regions.
- Implements facilities construction projects, provides technical assistance to individual project sites, provides contract management services and oversees the selection of A/E firms for VA's construction programs according to Federal and VA requirements and the evaluation of A/E performance in the design and construction of VA projects.

Office of Facilities Planning

Overview

The Office of Facilities Planning provides a wide array of strategic and consulting support and advice for all VA facilities master planning; project planning; space planning; environmental and historic preservation policy and technical assistance; cultural resources and environmental policy compliance; construction estimating; value engineering; design standards, criteria, specifications and standard details; and national physical security standards for facilities.

Functions and Activities

- Serves as the principal advisor to the Executive Director, CFM, on planning, architectural cost estimating, quality of project submissions, and manages the development and maintenance of VA architectural and engineering (A/E) quality standards for new and existing facilities. Provides consulting services for the VA's State Nursing Home Grant and Homeless Grant Programs and oversees VA's historic preservation and National Environmental Policy Act (NEPA) compliance issues.
- Develops design guides, construction standards, master specifications and guidance, and space criteria and coordinates VA facilities space requirements; oversees strategic planning and research on health care specialties and related space requirements, process engineering and layouts in accordance with Departmental policy.

- Provides policy guidance and support for enterprise-wide integrated planning.
- Provides master planning, technical advice, and training assistance to other VACO and field organizations.
- Provides consulting assistance on an as-needed basis to VA Administrations and Staff Offices on minor construction projects and nonrecurring maintenance (NRM).
- Takes a major role in VA's Strategic Capital Investment Planning process to ensure VA's assets are allocated and implemented in the best interest of the Department and VA.

Facility Planning Development Service

Overview

Facility Planning Development Service provides oversight on major construction project scopes and costs to ensure that Administrations' requirements are met, participates in project reviews, and is responsible for VA's Integrated Planning effort.

Functions and Activities

- Provides program management and process improvements for VA's Integrated Planning process.
- Forms relationships with VA Administrations, facilities leadership, Government agencies involved in project planning, the construction, and the A/E industry.
- Promotes the development of innovative and best practices for project design and planning throughout VA.
- Supports CFM's regional offices and other VA organizations by providing policy guidance and support for facility planning.
- Oversees the development of plans and designs for all CFM projects.
- Promotes the initiation and development of Cultural Resource Management Geospatial Information System tools.

Facility Standards Service

Overview

The Facility Standards Service develops policy and guidance for the oversight of functional space criteria management: architectural and engineering standards and master specifications; sustainability; functional design guides, technical discipline manuals; graphics and interior design; architectural barriers compliance; quality control; post occupancy evaluations (POE); multi-hazard physical security assessments of VA facilities; and preparedness standards for physical security, seismic, hurricane, and other natural and manmade disasters for all VA facilities.

Functions and Activities

- Develops and oversees planning, design, and construction standards and master specifications; building information modeling (BIM); sustainability including energy and water conservation; functional design guides; technical discipline manuals; design alerts; signage and interior design; architectural barrier compliance; post-occupancy evaluations; and multi-hazard physical security assessments of VA facilities and standards for physical security, seismic, hurricane and other natural and man-made disasters in accordance with established Departmental policy.
- Forms relationships with VA Administrations, program and facilities leadership, Government agencies involved in project planning and design, and the health care, construction and A/E industries.
- Promotes the development of innovative and best practices for project design, planning, and construction throughout VA. Takes a major role in VA's strategic planning and design process to ensure VA's assets are allocated and implemented in the best interests of the Department and Veterans.
- Develops guidelines and provides oversight and technical support training to CFM's regional offices and other VA organizations. Ensures that design and construction standards support the Administrations' concept of operations. Provides policy guidance and support for enterprise wide planning, design, and construction.

Cost Estimating Service

Overview

Cost Estimating Service provides oversight of the programs for construction cost budgeting, estimating overall construction, life-cycle costing, and value engineering.

Functions and Activities

- Develops requirements and provides guidance for the oversight of programs for construction cost, benchmarking, projections, and budgeting.
- Provides guidance and oversight of programs for construction cost estimating, benchmarking, cost escalation projects, and construction project budgeting.
- Estimates overall construction and life-cycle costs.
- Provides oversight of CFM's Value Management Program. Coordinates value engineering activities for project and standards development.
- Provides national and local market research for impacts to construction costs.

Authorities

Title 38 Part VI Chapter 81 Subchapter 1 §§ 8101-8119
Acquisition Reform Act of 2003 (SARA)

Office of Resource Management

Overview

The Office of Resource Management oversees the financial management of VA's major and minor construction programs, administrative budget, office administration functions, operations support, human resource management, travel, and training.

Functions and Activities

- The Office of Resource Management oversees the financial management of VA's major construction program and CFM's administrative budget as well as office administration functions, including human resources management, travel, training, space management, database management, office logistics, information technology (IT) equipment issuing and tracking.
- Serves as the principal advisor to the Executive Director of CFM on VA major construction, fiscal processes, IT resources, and human resources.
- Coordinates annual construction and leasing program estimates for VA's budget.
- Manages the major construction working reserve.
- Serves as primary point of contact on CFM organizational needs for integration of new technologies.
- Coordinates responses to OMB, GAO, IG, and FOIA requests for information.

Financial Management Service

Overview

Financial Management Service oversees financial resources and capital operating needs for Congressional submission, major construction operating plan; coordinates annual construction and leasing program estimates for VA's budget; and participates in presenting the construction and leasing budget to the Secretary, Office of Management and Budget (OMB), and Congress.

Functions and Activities

- Develops overall CFM financial strategy and provides fiscal fiduciary oversight for the management of major construction programs and CFM's operating funds, appropriations for design and construction funds for major capital projects.
- Develops and coordinates major construction and General Administration budget submissions.
- Monitors CFM's operating plan.
- Maintains and updates CFM's continuity of operations plan.

Database Management and Logistics Service

Overview

Database Management and Logistics Service coordinates CFM's information management business needs with oversight for coordinating the development of systems for operating needs, hardware/software support for all field worksites, space, and other information requirements.

Functions and Activities

- Develops policy for the coordination of CFM's information management business needs.
- Integrates emerging systems with current processes and platforms.
- Provides oversight for the coordination of the development of systems for operating needs.
- Coordinates hardware/software support for CFM's central office and field employees.
- Coordinates telecommunication needs, tracks government-furnished equipment, and electronic records management/storage.
- Plans and coordinates software development and upgrades.

HR and Training Service

Overview

HR and Training Service coordinates human resources actions of all CFM employees with the Central Office Human Resources Service to facilitate HR service for CFM employees.

Functions and Activities

- Provides coordination and oversight of the development of all HR-related documents; ensures quality of documents; and forwards completed documents on in a timely fashion.
- Coordinates with Central Office Human Resources Service regarding miscellaneous HR-related issues; resolves related problems or follows up on-going or hard to resolve issues; and provides advice to managers and employees concerning major areas of HR policy and process.
- Oversees the training function for all CFM employees; manages internal training programs for mission critical occupations; and coordinates with internal and external training organizations for relevant training and other developmental opportunities.
- Conducts special HR-related studies as needed by gathering pertinent information and presenting findings clearly and adequately.

Authorities

Title 38, Part VI, Chapter 81, Subchapter 1 §§ 8101-8119
Acquisition Reform Act of 2003 (SARA)

Office of Facilities Acquisition

Overview

The Office of Facilities Acquisition is responsible for developing policy and guidance for the oversight of contracting support for VA's construction program, real property management, and architectural-engineering (A/E) evaluation and selection services. It oversees the large and complex construction and lease projects for VA's three administrations and staff offices.

Functions and Activities

- The Office of Facilities Acquisition develops guidelines to properly oversee major construction and lease contracting, A/E selection, and provide technical support to CFM's regional offices. The Executive Director, CFM serves as the Head of Contracting Activity (HCA) for CFM.
- Serves as the principal advisor to the Executive Director, CFM on A/E, major construction and lease contracting.
- Provides A/E, construction and real property acquisition oversight for VA's Administrations and Staff Offices for major projects from capital asset application approval through project completion.
- Provides oversight and guidance to CFM's regional offices for major projects including renovations, replacement facilities, and additions.
- Oversees CFM leasing contract awards and administration.

Acquisition Support, National Region

Overview

Acquisition Support, National Region develops evaluation policy and guidelines, and provides technical support to the regional offices on a full range of activities including A/E firm evaluation and selection, contract negotiation, evaluation, and award activities covering all stages of the acquisition cycle for large-scale, highly complex major construction projects.

Functions and Activities

Manages construction-related strategic contracting activities:

- Manages the acquisition aspects of complex projects ranging from \$500 million to \$1 billion.
- Develops the overall acquisition strategy, timetable, financial aspects, and milestones to meet the targeted award and completion dates. Administers major construction's Federal Acquisition Certificate in Contracting (FAC-C) program.
- Manages all CFM requests for contracting certification to obtain warrants through the Office of Acquisition and Logistics.
- Oversees warrant management, acquisition, training, and develops acquisition training standards for CFM.

- Maintains a system of records for training requirements and warrant needs.
- Maintains certification records and coordinates the issuance of new or increased warrants for CFM employees.

AE Construction Contracting Policy Service

Overview

AE Construction Contracting Policy Service develops evaluation policy, guidelines, and overall acquisition strategy, timetables, financial aspects, and milestones to meet the targeted award and completion dates.

Functions and Activities

- Develops evaluation policy and guidelines and provides procurement support to CFM's regional offices on a full range of contracting activities, including A/E evaluation and selection, contract negotiation, and award activities covering all stages of the acquisition cycle.
- Compiles and tracks VA construction contracting goals for small and disadvantaged businesses.
- Facilities Acquisition Regional Offices: Acquisition Support National Region; Acquisition Support Eastern Region; Acquisition Support Central Region; and Acquisition Support Western Region oversee construction contract awards and administration of design and professional services contracts. Contracting activities involve a wide array of process administration for formal fixed contracts with A/E firms for services such as schematic design, design development, construction documents, and construction period services.
- Manages construction-related strategic contracting activities.
- Manages the acquisition aspects of complex projects.
- Develops the overall acquisition strategy, timetable, financial aspects, and milestones to meet the targeted award and completion dates.

Acquisition Support Director

Overview

The Acquisition Support Director oversees regional and local A/E evaluation and selection activities for projects in the assigned region; administers contracts for major project funding controls; and serves as action officers for emergent local acquisition situations.

Functions and Activities

- Oversees major construction contracting services for the assigned region (Facilities Acquisition Regional Offices: Acquisition Support – National Region; Acquisition Support – Eastern Region; Acquisition Support – Central Region; Acquisition Support – Western Region). The Director oversees construction contract awards and administration of design and professional service

contracts. Contracting activities involve a wide array of process administration for formal fixed contracts with A/E firms for services such as schematic design, design development, construction documents, and construction period services.

Authorities

Title 38, Part VI, Chapter 81, Subchapter 1 §§ 8101-8119
Acquisition Reform Act of 2003 (SARA)

Real Property Service

Overview

Real Property Service supports VA by acquiring land and leasing space for construction of medical and medically-related facilities; facilitating intergovernmental transfers, and the granting of easements licenses, and permits. It also provides guidance to regional and local VA offices regarding real property.

Functions and Activities

- Oversees administration of lease acquisition for medical facilities and reviews General Services Administration's (GSA) occupancy agreements on behalf of VBA.
- Provides support for independent negotiations, as well as negotiations with GSA, on issues pertaining to leasehold interests, land and building acquisitions, disposal of buildings and/or land, demolitions and related activities, licenses and permits, out-leasing, VA quarters management, parking, and compliance with the Randolph-Sheppard Act and the McKinney-Vento Act.
- Provides land management functions to all elements of the Department.

Authorities

Title 38, Part VI, Chapter 81, Subchapter 1 §§ 8101-8119
Randolph –Sheppard Act
McKinney-Vento Act
Acquisition Reform Act of 2003 (SARA)

Office of Programs and Plans

Overview

The Office of Programs and Plans is responsible for providing subject matter expertise and advice in all matters pertaining to VA's facilities and construction acquisition, real property acquisition and disposal, and quality assurance of acquisition projects.

Functions and Activities

Develops a national program strategy for construction acquisition, real property acquisition and disposal, and program quality assurance:

- Serves as the principal advisor to the Executive Director of CFM for issues associated with construction acquisition, real property acquisition and disposal, and program quality assurance.

- Develops policy, guidance, and performance measures for the acquisition oversight of construction and leasing programs.
- Provides technical support to CFM's regional offices.
- Maintains construction and leasing performance measurement and reporting systems.
- Oversees the administration of programs to assess organizational achievement and individual performance.
- Develops management and review processes to ensure pilot projects produce a return on investment and that thorough processes will be instituted across the entire facility management spectrum.
- Solicits, evaluates, and implements improvements to the capital asset program project management and execution.
- Provides oversight to the VA's Implementation of effective project management, assuring a project management plan that addresses project staffing, responsibilities, master schedule and budget, and is scalable to major, minor, and maintenance projects.

Consulting Support Service

Overview

Consulting Support Service is responsible for providing subject matter expertise and advice in all matters pertaining to VA's design and construction programs, and ensures a full array of technical professional consultation is provided to regional offices.

Functions and Activities

Develops and provides guidance for all facilities engineering activities in CFM and provides support on A/E issues; provides subject matter expertise for VA's design and construction programs, as well as construction contract claims.

- Serves as the principal advisor to the Executive Director of CFM, on all engineering and operations services for VA's design and construction programs.
- Provides direct on-call consulting support to field installations and CFM regional offices.
- Provides consultations and support services related to A/E design services, automated transport design, conceptual and design development support, and engineering design services.
- Provides other key services including guidance on facility condition assessments, technical/building studies, critical path method scheduling and training, and subject matter expertise for claims management.
- Provides emergency response teams for natural disasters or other emergencies affecting VA assets to assess, document damage and critical safety issues, and develop recommendations for corrective action.

- Oversees facility condition assessments, electrical studies, suitability assessments, and façade studies.
- Participates and provides technical expertise in major design reviews, facility commissioning, and emergency preparedness assessments.

Authorities

Title 38, Part VI, Chapter 81, Subchapter 1 §§ 8101-8119

Acquisition Reform Act of 2003 (SARA)

Project Control Service

Overview

The Project Control Service manages and directs departmental platform of activities to assure development of construction program policy, focusing on communication and key processes of time management, cost management for CFM's business lines; and oversees systems that provide real time access to all relevant construction program information.

Functions and Activities

- Provides technical and professional support and develops recommendations for improved processes and procedures including acquisitions planning, project design, construction management, as well as oversight and management of contracts for professional A/E services, construction managers, design-build contractors, and all other construction contracts.
- Conducts reviews to assess the viability of a project, determine weakness and ensure improvement in the areas not meeting the standards.
- Oversees development of detailed construction program action plans, determines if current structures are appropriate to the intended strategy, articulates proposed strategies, links, strategic planning to the annual business plan and budget; and monitors and controls the plan to determine if strategy is on track.
- Oversees and coordinates interfaces with field contacts by managing integrated master schedules , program controls, and multifaceted construction program services providing the necessary training tools to ensure that personnel are proficient in project management fundamentals needed to effectively and efficiently plan, design, and manage a project.
- Manages construction program support encompassing professional services for acquisition planning, project design and construction management identifying policy elements that may likely give rise to disputes and/or claims.
- Establishes and maintains program review boards with CFM directors and oversees the administration of programs that assess organizational achievement and individual performance; and recognizes the congruence between individual needs, organizational climate, job satisfactions, and performance.

- Other tasks include directives management, development of organizational performance measures, lessons learned, and benchmarking best practices in cost and pricing data for the major construction program.

Quality Assurance Service

Overview

Quality Assurance Service provides an independent quality assurance program for CFM business lines, ensuring compliance with applicable VA and Federal regulations and requirements.

Functions and Activities

- Provides an independent quality assurance program for CFM's business lines, ensuring compliance with applicable VA and Federal regulations and requirements.
- Conducts independent compliance reviews of purchase card transactions, major construction projects and leases to ensure adherence to Federal Acquisition Regulation (FAR), VA, and CFM policy.
- Provides technical writing and editing services to all CFM offices to support the drafting and issuance of policies and standard operating procedures for all CFM functional areas.
- Conducts construction peer reviews during the construction period of major projects for purposes of assessing and improving CFM/contractor working relationships and project delivery efficiencies.

Veterans Benefits Administration

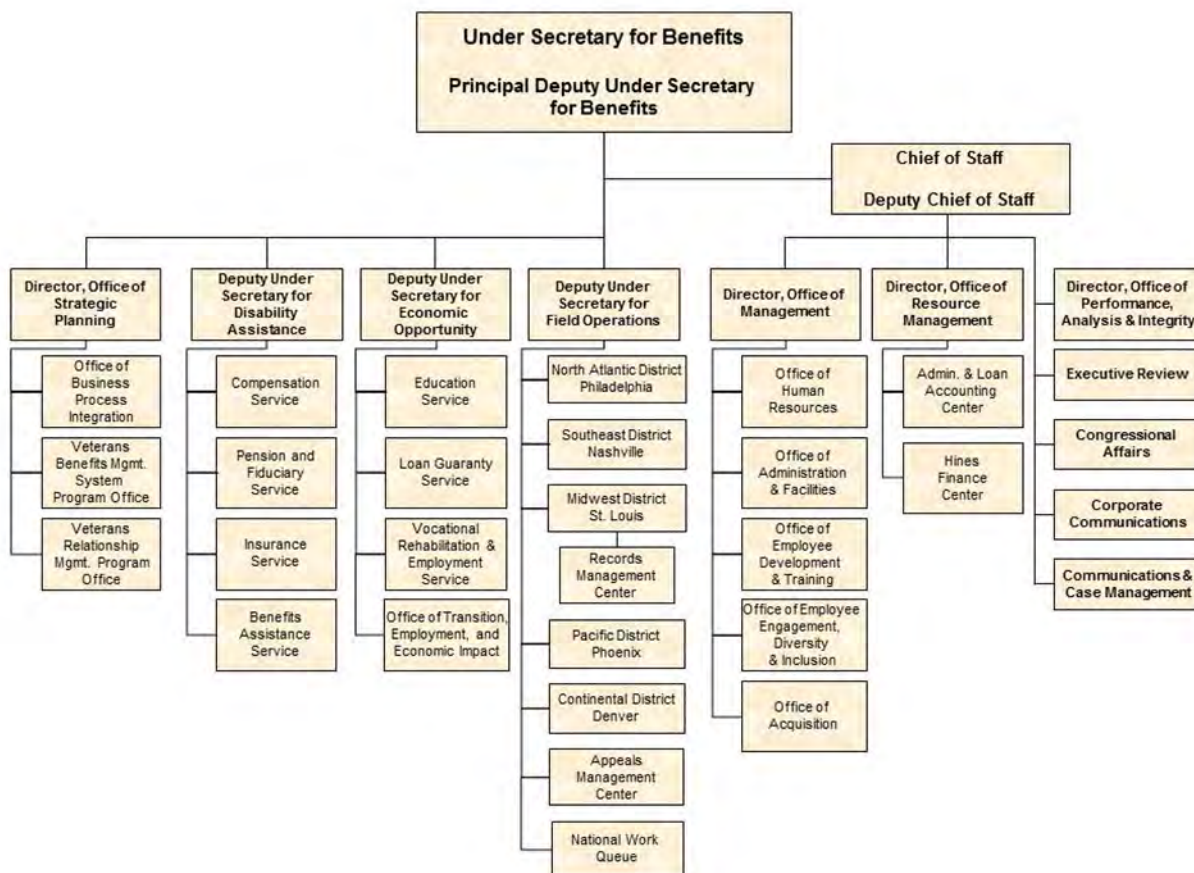


Figure 11 - Veterans Benefits Administration Organization Chart

[Click here for the alternate representation of the chart](#)

Office of the Under Secretary for Benefits

Mission

The mission of the Veterans Benefits Administration is to provide benefits and services to Veterans, their families and survivors in a responsive, timely, and compassionate manner in recognition of their service to the Nation.

Overview

The USB's Office supports the Under Secretary for Benefits (USB) in leading and directing the Veterans Benefits Administration (VBA). The Office of the USB is headed by the USB and includes the Principal Deputy Under Secretary (PDUSB), Chief of Staff (COS), and Deputy COS. The USB, PDUSB, and the COS provide senior executive leadership for VBA.

Functions and Activities

The USB leads and directs the delivery of Compensation, Pension, Education, Vocational Rehabilitation and Employment, Loan Guaranty, and Insurance benefits.

- Communicates VBA's vision, principles, policies, goals, expectations, and outcomes to the Office of the Secretary, other VA departmental officials, Office of Management and Budget (OMB), Congress, the Government Accountability Office (GAO), Veterans, Veterans Service Organizations (VSOs), other Federal agencies, and external stakeholders.
- Coordinates critical policy and program issues throughout the organization and externally. Establishes and implements clear policies, practices, and management controls for all VBA programs. Establishes standards and policies on national workforce issues.
- Develops long-range plans and policies that impact VBA's long-term direction and strategy.
- Provides briefings, speeches, congressional testimony and high-level presentations regarding Veterans benefits programs, to include both program oversight information and recommendations for new program initiatives.
- Manages and controls communications and fosters greater cooperation and communication both to and from internal and external stakeholders.
- Collaborates with the Department of Defense (DoD) to expand information sharing and identify improvements in benefits delivery and claims processing. Serves as Co-Chairperson of the Benefits Executive Council (BEC) and a member of the Joint Executive Council. Works with the Wounded Warrior Care and Transition Office and other DoD entities. Coordinates, develops, and recommends milestones for the BEC working groups that are reported in the Joint Executive Council (JEC) Strategic Plan and Annual Report.
- Establishes committees, advisory groups, and review bodies as necessary to provide information and advice to the USB.

Office of the Chief of Staff (20A)

Overview

The VBA Office of the Chief of Staff (COS) works closely with the USB, PDUSB, and the Deputy Under Secretaries to manage VBA's day-to-day operations. The Office of the COS serves as VBA's central coordination point for all high-level negotiations involving the establishment or implementation of policies, procedures, management, and operational activities of the Department and VBA. The COS manages VBA's executive correspondence, corporate communications, congressional and legislative affairs, and development of regulations. The COS provides executive leadership to the following offices: Office of Management, Office of Resource Management, Office of Performance Analysis and Integrity, Office of Communications and Case Management, and Office of Corporate Communications.

Functions and Activities

The Office of the COS works closely with the USB to manage the day-to-day operations of the VBA.

- Coordinates the policies, plans, and operational approaches designed to most effectively carry out the mission of VBA.
- Coordinates, disseminates, and responds to all requests for information from VBA by the Department and the White House.
- Coordinates, disseminates, and responds to all requests for information from external stakeholders, such as Members of Congress, VSOs, other Governmental agencies, and the general public.
- Ensures that VBA's communications are clear, concise, accurate, and aligned with VA's position and strategic direction.
- Manages VBA's Executive Correspondence Program to provide timely and accurate responses to inquiries by Congress and affiliated offices (Congressional Budget Office, Congressional Research Office, etc.), as well as, Veterans, Veterans' families, and the general public.
- Provides written testimony, prepares briefings, and prepares effective support to witnesses preparing for hearings and briefings that have an impact on the VHA and VA.
- Ensures that VBA works closely and effectively with our partners throughout the Department, including but not limited to the OSVA, Office of Management (fiscal and budget issues), OCLA, OPA, OGC, and OPP.
- Oversees VBA's corporate communications processes and efforts to strengthen VBA's relationship with Veterans, Servicemembers, and their families.

Office of Corporate Communications (20A4)

Overview

The Office of Corporate Communications has overall responsibility for internal and external communications and public affairs activities.

Functions and Activities

Collaborates with VBA service, staff, and regional offices to define, plan, and execute VBA's internal and external communications objectives.

- Creates a communications framework for the distribution of information and provides communications support to all VBA programs
- Prepares communications plans, public affairs guidance, news releases, formal speeches, key messages, infographics, videos, HeyVBA articles, and other information material as needed for release both within and outside VA.
- Leads VBA's media relations effort and assists the department and the field with media queries and public affairs training to VBA senior leaders and regional office public affairs officers.

- Develops and executes integrated communications plans on transformation, VBA benefits and services, and special initiatives. Promotes VBA's transformation and greater public awareness of VBA's mission.
- Provides full communications support for VBA senior executive speaking engagements, including the creation of formal speeches, official briefings and informal presentations
- Embeds VBA communications planning and processes in future VBA transformation efforts.
- Works in close coordination with the Benefits Assistance Service's Web Communications team to ensure consistent messaging through VBA's website and its various social media platforms.

Executive Review (20A11)

Overview

Executive Review has overall responsibility for the management and processing of controlled correspondence from Congress and affiliated offices (Congressional Budget Office, Congressional Research Office, etc.), Veterans Service Organizations, other public and private sector individuals and groups, as well as Veterans, Veterans' families, and the general public.

Functions and Activities

- Ensures program and staff office adherence to controls for assigned communications and also monitors for compliance.
- Reviews all correspondence to maintain uniformity and consistency with Administration and Departmental policy, plans, and objectives.

Congressional Affairs Office (20A2)

Overview

The Congressional Affairs Office has overall responsibility for VBA congressional and legislative activities.

Functions and Activities

- Serves as the liaison for congressional oversight requests, including coordinating hearing preparation, briefing requests, site visits, and responding to email inquiries.
- Analyzes new or amended legislation that would impact Veterans benefits programs.
- Coordinates VBA's legislative proposals in OMB's A-19 process. Collaborates with program offices to develop proposals and obtain concurrence.
- Coordinates congressionally mandated reports to authorizing committees and congressional tracking reports to appropriating committees.

Office of Communications and Case Management (20A3)

Overview

The Office of Communications and Case Management has overall responsibility for all activities related to resolving and responding to inquiries from Veterans that have reached the level of the SECVA and USB.

Functions and Activities

- Provides expertise on special issues and problems requiring in-depth technical analysis.
- Develops pertinent facts and communicates with senior officials to resolve issues.

Office of Strategic Planning (20S)

Overview

The Office of Strategic Planning (OSP) directs and coordinates future concepts, strategic and operational planning, programming, and transformational initiatives for VBA. OSP provides input to the Office of Policy and Planning (OPP) quadrennial planning process. OSP conducts analysis of future trends and forecasts to identify promising business transformation initiatives, provides governance, and encourages the use of project management to develop those initiatives. OSP manages business process transformation and facilitates the governance process for future resource allocation.

OSP plays a key role in two of VBA's governance organizations. First, OSP is the secretariat of the Planning and Programming Review Board (PPRB) that is responsible for recommending approval of planning and programmatic requirement and prioritizations for VBA business lines and support staff. Under the direction of the PPRB, the Benefits Technology Work Group has been established and is co-chaired by the OSP Deputy Director of Strategic Planning. It is responsible for gathering and integrating the business technology requirements from each Line of Business (LoB) in order to create the VBA business technical architecture. Second, OSP is the secretariat of the Transformation Governance Board responsible for standardizing the process through which innovative concepts are identified, developed, and implemented for VBA's benefit.

OSP executes its mission through the following three divisions:

Strategic Planning:

The Strategic Planning division leads and coordinates VBA strategic and operational planning efforts by helping VBA business lines and staff offices implement the VA and VBA strategic plans and Agency Priority Goals (APG). The Planning division also serves as the co-chair on the Benefits Technology Working Group (BTWG).

Programming:

The Programming division leads and coordinates VBA's programming efforts among VBA business lines and provides a systematic approach to allocating resources to satisfy the agency's statutory and regulatory duties.

Transformation Initiatives and Future Concepts (TI&FC):

The TI&FC division identifies strategic gaps in VBA operations and develops relevant solutions to address business needs. Working with the Programming and Strategic planning divisions of OSP, TI&FC provides analytical expertise to observe, identify, and address patterns in the internal and external operating environment that could emerge as barriers to or opportunities for organizational success. In collaboration with VBA business lines and support offices, TI&FC develops and executes program initiatives to inform leadership of recommended process changes.

Functions and Activities

- Directs VBA's year-round strategic planning efforts, ensuring plans support the Department's Agency priority Goals (APG's), and strategic goals and objectives.
- Implements the USB's guidance and vision and coordinates the planning activities of the program and staff offices.
- Co-chairs the BTWG, a committee established by the VBA Planning and Programming Review Board (PPRB) to ensure that business technology priorities support VBA long-range goals, objectives and priorities.
- Develops, recommends and coordinates transformational initiatives designed to improve delivery of benefits and/or VBA operations in the field. Examines and develops future concepts for the to-be state and future capabilities of VBA.
- Promotes a culture of collaboration, synergy and strategic thinking by bringing stakeholders into the planning and programming process and supporting those who provide benefits and services. The collaboration is designed to develop planning and programming skills throughout VBA lines of business and staff offices.
- Embraces the understanding that VA engages with Servicemembers and Veterans from the time they enter uniformed service until they are memorialized at the end of life. Their life long engagement requires understanding of who has served, is serving today, and who will serve in the future. We must plan for their transition out of the service so that they are enabled to continue to serve their communities and nation outside of uniform as they did in uniform.

Authorities

38 U.S.C. § 306 Chapter 77
38 CFR § 2.6(b)

Office of Business Process Integration (20C)

Overview

The Office of Business Process Integration (OBPI) ensures that VBA's strategic needs and requirements for business and data systems are properly documented, integrated, and communicated. OBPI works with the OIT to facilitate the design, development, and implementation of business systems and information technology to enhance claims processing within VBA.

Functions and Activities

OBPI identifies the strategic business needs for VBA's IT systems.

- Develops and maintains a comprehensive VBA strategic vision for business and data systems.
- Manages business resources dedicated to VBA's legacy business IT systems and all other IT systems, and identifies key operational business requirements related to these IT systems.
- Manages VBA business and data systems investments to maximize return on investment.
- Supports "One VA" initiatives.
- Supports VBA Business Governance processes (portfolio reviews).
- Maintains an active list of portfolio initiatives for business systems/business capabilities.
- Conducts program and milestone reviews of each business line's project portfolio
- Identifies opportunities for portfolio integration and improvement.

OBPI facilitates the design, development, and implementation of VBA's business and information technology systems used for claim processing within VBA.

- Identifies and documents cross-cutting business requirements.
- Coordinates and executes large-scale, cross-cutting initiatives.
- Ensures business needs and requirements are properly documented, integrated, and communicated both internally and externally.
- Oversees the implementation of Veterans Service Network (VETSNET) enhancements and fixes.
- Prepares requests for development and information sharing activities.
- Coordinates with VBA's business lines and external agencies to develop and control business data sharing agreements.
- Develops and executes business application deployment strategies in coordination with the Office of Field Operations.

- Validates that applications meet business requirements and ensures new functionality fits seamlessly into existing environments through testing.
- Executes the preparation of business applications for production release.

OBPI manages VBA business and data systems to maximize return on investment.

- Identifies and documents cross-cutting processes.
- Collaborates and consults on IT budget execution.
- Represents VBA in the IT governance model.
- Provides oversight and executes the VBA governance plan.
- Executes acquisition management.
- Executes correspondence management and control.

OBPI facilitates the development of data requirements and integrates these elements across key business systems.

- Supports VBA long-term planning of business systems support.
- Identifies data requirements for critical business systems.
- Engages development teams and business sponsors to address the issues of data governance and data integrity across business systems and platforms.

OBPI facilitates the development of business reports and integrates these elements across key VBA IT systems.

- Coordinates VBA's effort to develop key business reports.
- Engages development teams, business sponsors, and VBA leadership to address the issues related to developing reports, information access, and information transparency.

OBPI oversees the Veterans Claims Intake Program (VCIP).

- Develops, manages, and controls the claims intake Concept of Operations, Roadmap, and Transition Plan. Provides deployment planning and coordinates claims intake releases.
- Defines, manages, controls, and coordinates the delivery of claims intake solutions, including document conversion (scanning) and post-scanning disposition of disability claims source material.
- Provides acquisition management support including acquisition planning, acquisition package development, and source selection for services associated with intake, conversion, mail handling, and post-scanning disposition.

- Ensures oversight and analysis for greater than 99 percent scanning accuracy to support System of Record designation.
- OBPI oversees Centralized Mail (CM), a business transformation initiative that allows for the transition from a paper-based system to a process where all claims data is received digitally or is digitally scanned into the claim system.
- CM has been deployed to all 56 ROs and will be complemented by improved business processes and workflows employing rules-based claims development and decision recommendations.
- OBPI is working to incorporate other VA offices into CM to include VR&E, PMC, BVA, and the RMC.

Authorities

38 U.S.C.

38 CFR

Veterans Benefits Management System Program Management Office (20S1)

Overview

The Veterans Benefits Management System (VBMS) Program Management Office (PMO) is developing an end-to-end paperless claims processing system that incorporates improved business processes with technology. VBMS will assist in eliminating the claims backlog and serve as the enabling technology for quicker, more accurate, and integrated claims processing in the future.

The mission of VBMS is to help improve the timeliness and quality of claims decisions and processes, and help our Veterans receive the high degree of service they expect and deserve.

Functions and Activities

The VBMS PMO provides critical cross-program services, skills, and knowledge focused on the detailed business aspects of the integration and delivery of specific projects within the VBMS program.

- Ensures operational environment is established and ready to accept the deployed solution (facilities, infrastructure, trained staff, help desk, etc.). Serves as the primary point of contact to regional offices and other end-users on matters related to transition management.
- Prepares analyses of alternative deployment strategies and selects or develops deployment strategy, directs the solution delivery schedule, serves as principle VBA representative on deployment matters, and coordinates the implementation of VBMS PMO efforts related to deployment, training and communications in concert with VBA Office of Field Operations.
- Establishes solution performance targets and assesses performance of deployed pilots or phased roll-outs against performance targets.
- Conducts user-acceptance testing, including acceptance sign-off, and coordinates with Business Requirements Division in the development of user-acceptance testing procedures.

- Identifies and documents end-user training requirements, provides training, creates and distributes training resources.

The VBMS PMO manages activities associated with the administration and investments for VBMS program.

- Coordinates the statements of work, independent Government cost estimates, source selection plans and other acquisition package materials.
- Formulates and executes the General Operating Expense (GOE) budget and supports OIT Exhibit 300 budget justification activities associated with the VBMS program.

The VBMS PMO manages program governance and performance management activities, and develops and implements key control processes for the VBMS program.

- Promotes adherence to VA standards and practices.
- Develops and implements key control processes, such as risk, schedule, configuration, and performance management processes.

The VBMS PMO leads strategic planning and tactical efforts for stakeholder engagement, organizational change management to ensure a clear, consistent understanding of the VBMS program.

- Develops and implements training, workforce readiness, and communication strategies to prepare the VBA workforce to successfully transition to new processes and technology.

The VBMS PMO leads the development, definition, and management of business requirements for all VBMS program stakeholders.

- Represents VBA to regional offices on matters related to gathering business requirements for VBMS.
- Formalizes the business process requirements.
- Re-engineers business processes, to include automation.
- Develops and conducts user testing scenarios.
- Analyzes and recommends business policy and procedure updates to Compensation Service, Pension and Fiduciary Service, and Office of Field Operations resulting from re-engineering decisions.

Authorities

38 U.S.C. § 306 Chapter 77

38 CFR § 2.6(b)

Veterans Relationship Management Program Management Office (20S2)

Overview

The Veterans Relationship Management (VRM) Program Management Office (PMO) is an enterprise initiative that engages, empowers, and serves Veterans and other clients with seamless, secure, and on-demand access to benefit information and services. The VRM PMO is currently detailed to the Veterans Experience Office (VEO) pending permanent transfer to VEO in FY 2017.

Functions and Activities

The VRM Program Management Office manages the Veterans Relationship Management Initiative's acquisitions and contracts by developing capabilities and enabling systems to drive performance and outcomes.

- Formulates and executes the VRM General Operating Expense (GOE) budget and supports OI&T Exhibit 300 budget justification activities associated with the VRM program.
- Coordinates the performance work statements, independent Government cost estimates, source selection plans, unfunded requests, and other acquisition package materials.

The VRM PMO manages the testing, deployment, and internal and external communications for projects developed by this initiative.

- Coordinates the marketing and branding of the initiative with strategic planning and communications for internal and external stakeholders and customers to ensure a message of continuity and clarity is communicated to Veterans and their families
- Manages and provides support for a seamless organizational transition throughout the initiative.
- Coordinates, facilitates, and supports training prior to system deployment and implementation across the Nation and across all stakeholder initiatives.
- Develops and manages stakeholder relationships to ensure VA is improving quality and accessibility of benefits to Veterans, increasing Veterans' satisfaction, providing services continuously, and improving VA employee satisfaction.

The VRM PMO oversees program planning that follows a strong VA-integrated operating model with a focus on VA's strategic principles of being people centric, results driven, and forward looking.

- Manages the performance reporting system and implementation by enabling convenient and seamless interaction across the initiatives.
- Manages and supports configuration control for the initiative by creating organizational value and driving performance and outcomes.
- Ensures program standards across the initiative to reduce cost, maintain quality, and meet emergent national needs.
- Oversees program scope and schedule to ensure the effective delivery of world-class benefits with financial resources.

The VRM PMO manages the oversight of business processes to establish a strong VA management infrastructure and integrated operating model.

- Oversees the requirements development and traceability process to ensure base-line deliverable documents within scope pursuant to Project Management Accountability System standards.
- Develops business use case scenarios and oversees user acceptance testing results that enable 21st century benefits delivery and services.
- Develops policies and procedures that improve the readiness to provide services as needed in a time of crisis.
- Coordinates the design of Veteran-centric systems and infrastructure with the National Call Centers, VHA, NCA, and other Federal agencies, such as DoD, Department of Health and Human Services, and Social Security Administration to enable 21st century benefits delivery and services.

Authorities

38 U.S.C. § 306 Chapter 77

38 CFR § 2.6(b)

Office of the Deputy Under Secretary for Disability Assistance (20P)

Overview

The Office of Disability Assistance (ODA) oversees the administration of certain benefits and services to Servicemembers, Veterans, their family members, and survivors.

Functions and Activities

The Office of Disability Assistance coordinates initiatives, projects, and procedural changes for four of the VBA's seven business lines: Compensation Service, Pension and Fiduciary Service, Insurance Service, and Benefits Assistance Service.

- Coordinates input from the business lines for VBA's Annual Benefits Report that summarizes benefits and services provided by VBA.
- Coordinates and compiles data from the business lines for briefings to VBA leadership on activities and achievements.
- Ensures transformation initiatives are executed and aligned with VBA objectives.
- Directs and oversees new initiatives, objectives, policies, and standards established to improve VBA services and programs.
- Develops and presents solutions to problems that affect day-to-day program management activities.

ODA formulates and promulgates policies, regulations, plans, procedures, guidance, and instructions necessary to implement and maintain effective program operations for all business lines.

- Develops performance measures and conducts performance reviews to assess the functional capabilities of program areas within the business lines.
- Reviews proposed legislation and Executive Orders to conduct long-range planning and evaluate immediate and long-term impacts on the fiscal, manpower, and economic resources of the business lines.
- Recommends changes to current laws to make Veterans benefit programs more goal-oriented, equitable, and efficient.
- Provides technical and professional direction to the business lines regarding benefit programs, such as policy statements, program guides, manuals, general operating instructions, and program evaluations.

ODA analyzes Department-wide programs, functions, and organizations to determine whether current management systems efficiently accomplish objectives and whether they provide controls necessary for sound management.

- Maintains an efficient system of internal and external program integrity, coordinates integrity issues with the GAO and OIG, and ensures that the business lines implement appropriate corrective actions.
- Issues directives to the business lines regarding internal management and informs VBA leadership of accomplishments and operational problems within the program areas.

ODA formulates, executes, and analyzes budgets and resources.

- Reviews business-line needs and budget submissions for execution and formulation of their programs.
- Analyzes efficiencies and reassigns resources as needed to support the achievement of major VA initiatives.
- Evaluates budgetary compliance and develops planning mechanisms to forecast needs of the business lines.
- Participates in congressional hearings, conferences, and meetings to gain compliance, address and resolve issues and concerns relating to program activities.

ODA supports VBA governance plan/portfolio for implementation and design of information technology systems.

- Advises and represents business lines at the Benefits Portfolio Executive Board and Benefits Portfolio Steering Committee meetings on various IT projects aimed to maximize the efficient delivery of benefits and services to Veterans.

- Identifies resource requirements to develop the policies and procedures of VBA systems, to achieve results, and safeguard the integrity of VBA programs and data.
- Ensures business line compliance with developing VBA systems to maintain accountability in processes and sustain the strategic goals and objectives of the organization.

ODA conducts, plans, and organizes special or confidential projects, and/or management-directed studies.

ODA facilitates VBA's collaborative relationships with intergovernmental and non-governmental organizations.

- Coordinates the USB's collaboration with VSOs, the BEC, the Senior Oversight Committee, and other entities to expand information sharing and identify improvements in benefits delivery and claims processing.
- Communicates program objectives to OMB, OIG, GAO, state and local government agencies, and congressional officials.

Authorities

38 U.S.C. § 306 Chapter 77

38 CFR § 2.6(b)

Compensation Service (21C)

Overview

The mission of Compensation Service is to provide monthly payments to Veterans in recognition of the effects of disabilities incurred or aggravated from diseases, injuries, or events during active military service.

Functions and Activities

Compensation Service develops rulemaking and policy requirements, and conducts advisory reviews in support of the compensation benefit program:

- Drafts proposed and final rules.
- Develops, maintains, and updates Disability Benefits Questionnaires (DBQ).
- Advises on operational and policy requirements to implement the law and effect leadership decisions regarding compensation.
- Conducts advisory reviews, participates in special case reviews and prepares decision assessment documents to analyze the effects of decisions by the U.S. Court of Appeals for Veterans Claims and the U.S. Court of Appeals for the Federal Circuit.
- Represents Compensation Service on legislative and policy matters and special projects.

Compensation Service develops and disseminates procedures for the administration of the compensation benefit program.

- Issues and administers procedural guidance implementing initiatives and laws governing VA benefits.
- Liaisons with external stakeholders, such as the Department of Defense, Social Security Administration, and the Department of Justice, to provide subject matter expertise on Veterans benefits and appropriate system access.
- Collaborates with VBA stakeholders to develop and support system requirements for automation and other functionality.
- Updates the VBA manual, M21-1, *Adjudication Procedures*.
- Creates and maintains forms and letters used in the adjudication of compensation benefits.
- Establishes and maintains computer-matching agreements between VBA and other Government agencies.

Compensation Service develops, facilitates, and oversees training and implementation of the skill-certification tests for VA employees involved in processing compensation claims and appeals.

- Develops, supports, and facilitates training for new, intermediate-, and journey-level employees.
- Develops, supports, and monitors the National Training Plan for claims processors.
- Collaborates with the Office of Field Operations and regional offices to ensure that all training products are accurate and consistent with Compensation Service directives and meet the needs of claims processors to produce accurate and timely decisions.
- Collaborates with contractors to develop new training products and methods of training delivery that utilize cutting-edge technology and allow desktop delivery to remote locations.
- Develops and facilitates specialized training for Military Service Coordinators (MSCs).
- Collaborates with the Office of Field Operations to ensure MSC training is accurate and relevant to the needed knowledge, skills, and abilities.

Compensation Service facilitates and monitors several multi-million dollar contracts to obtain medical disability examinations and support Compensation Service initiatives.

- Works with the contractors, regional offices, and VBA leadership to ensure all contracts maximize claim processing capacity while improving, timeliness and accuracy.
- Develops and monitors contracts to audit the invoices received from the medical disability examination contractors and to report customer satisfaction scores for the medical disability examination contractors.
- Leads a team of contractors and field subject matter experts in developing and revising skill certification tests for employees and managers involved in claims processing.

- Monitors the performance of the contractor in facilitating and management of the skill-certification tests.
- Collaborates with the Office of Field Operations, regional office representatives, contractors, and Compensation Service staff to monitor the relevance and accuracy of the skill certification test content.

Compensation Service assesses claims processing accuracy nationwide for rating and authorization workload.

- Controls and oversees the Systematic Technical Accuracy Review (STAR) program, which conducts rating consistency and special focus reviews with regular, random samples from each station.
- Conducts monthly rating quality calls to disseminate STAR results/information to regional office personnel.
- Posts monthly STAR reports for current and previous fiscal year to STAR Web page.
- Publishes monthly quality call notes with articles on site visits, rating and authorization accuracy, rating consistency, and VHA exam reviews to support efforts to improve quality at the regional office level.
- Analyzes quarterly rating data for most common diagnostic codes to identify inconsistencies in regional office rating determinations.
- Conducts focused, audit-style reviews of samples of rating decisions based on results of data analysis described above.
- Administers studies to assess nationwide consistency in eligibility determinations.
- Collaborates with VHA's Disability and Medical Assessment Program Office (DMA) on VBA's compensation and pension examination requests process. This includes monitoring the accuracy and timeliness of compensation and pension examination requests nationwide, and the Disability Benefits Questionnaires Switchboard.
- Conducts nationwide site visits to ensure regional offices follow VBA policies and procedures pertaining to compensation.
- Updates the VBA manual, M21-4, Manpower Control and Utilization in Adjudication Divisions.

Compensation Service enables the responsive and timely delivery of compensation and pension benefits through the development and maintenance of business line software applications, systems, and data.

- Develops VETSNET claims processing functionality to include business process analysis, requirements, testing and training, and help desk support.

- Develops new claims processing functionality to include business process analysis, requirements, testing, training, and help desk support, as well as business-side management of most critical compensation non-VETSNET/non-Virtual VA applications.
- Develops and maintains the Virtual VA suite of applications, a technology for paperless claims processing that increases the timeliness of responses to Veterans' inquiries and claims by eliminating the limitations associated with physical records.
- Provides critical support for any initiative aimed at reducing the use of paper in compensation claim processing including interagency partnerships.
- Leads the Private Medical Records program that utilizes private vendor claims development assistance to obtain Veterans' medical records from non-VA physicians.

Compensation Service addresses the tools, behaviors, and organizational changes necessary to improve internal service efforts and activities that cross business lines.

- Outlines business processes for collaboration and develops plans for execution.
- Identifies and recommends work environment tools to assess progress through metrics and employee feedback.
- Establishes new ways to interact with employees and encourage their participation in the development of procedures.
- Gathers feedback from employees and other stakeholders to assist community collaboration.

Authorities

38 U.S.C. Chapters 1, 11, 18, 51, 53, 61, 77

38 CFR Parts 34

Federal Advisory Committee Act (1972),

5 U.S.C. Appendix 2

Pension and Fiduciary Service (21PF)

Overview

The Pension and Fiduciary (P&F) Service administers VA's needs-based pension program for wartime Veterans and their survivors, the parents' dependency and indemnity compensation (DIC) program for dependent parents, DIC program for the survivors of Veterans who die as a result of service-connected disabilities, and burial benefits program for survivors and other individuals who paid for the burials or funerals of deceased Veterans. P&F Service also administers VA's fiduciary program for beneficiaries who cannot manage their VA benefits.

Functions and Activities

The P&F Service manages and oversees the Department's fiduciary program.

- Develops, maintains, coordinates, and implements the regulations, policies, and procedures governing the fiduciary program.

- Provides technical, program-specific advice regarding existing and proposed legislation affecting the fiduciary programs.
- Develops, maintains, and implements national training standards for VA employees adjudicating fiduciary requirements. Develops, validates, maintains, and deploys printed and electronic materials supporting classroom and online training for the fiduciary programs.
- Conducts national quality reviews of regional offices and fiduciary hub decisions.
- Develops protocols for and conducts site assistance visits for the purposes of (1) assisting the regional offices and fiduciary hubs in complying with published policies and procedures, (2) identifying areas for improvement, and (3) establishing best practices.
- Addresses the concerns of external and internal stakeholders in matters related to the fiduciary program.
- Conducts outreach to educate individuals, train current fiduciaries, and recruit potential fiduciaries willing to serve beneficiaries in their best interests.
- Works with VA business lines to improve current information technology applications and create new applications to enhance the timeliness, quality, and transparency of fiduciary decisions.

In administering the pension, DIC, parents' DIC, and burial benefit programs, P&F Service:

- Develops, maintains, coordinates, and implements the regulations, policies, and procedures.
- Provides technical, program-specific advice regarding existing and proposed legislation.
- Develops, maintains, and implements national training standards for VA employees who adjudicate claims.
- Develops, validates, maintains, and deploys printed and electronic materials supporting classroom and online training.
- Conducts national quality reviews of adjudication decisions performed at the VA Pension Management Centers (PMCs).
- Develops protocols for and conducts site visits for the purposes of assisting the PMCs in complying with policies and procedures, identifying areas for improvement, and establishing best practices.
- Addresses the concerns of external and internal stakeholders in matters related to programs administered by P&F service.
- Coordinates with the Benefits Assistance Service to improve the outreach efforts to Veterans and survivors.
- Works with various business lines to improve current information technology applications and create new applications to improve the timeliness and transparency of benefit decisions.

Authorities

38 U.S.C. § 1315 Chapters 1, 13, 15, 23, 51, 53, 55, 61

38 CFR Parts 3, 13

*Insurance Service (29)***Overview**

The Insurance Service provides Veterans with life insurance benefits that may not be available from the commercial insurance industry due to loss or impaired insurability resulting from military service, and provides universally available life insurance benefits to Servicemembers and their families, as well as traumatic injury protection insurance for Servicemembers. VA will provide all benefits and services in an accurate, timely, and courteous manner at the lowest achievable administrative cost. VA will provide insurance coverage in reasonable amounts at competitive premium rates. VA will ensure a competitive, secure rate of return on investments held on behalf of the insured.

Functions and Activities

Insurance Service provides the same or better life insurance benefits than those available to private citizens when these programs were established. These include the National Service Life Insurance (NSLI), United States Government Life Insurance (USGLI), Veterans' Special Life Insurance (VSLI) and Veterans' Reopened Insurance (VRI) programs.

- Pays insurance disbursements, including death claims, loans, and cash-surrender requests.
- Maintains current policies by handling policyholders' requests, including processing dividend distributions, change-of-plan, and reinstatement requests.
- Offers a variety of options for policyholders to pay their USGLI premiums, including deduction from compensation or pension benefits, deduction from annual dividend distribution, deduction from retired service pay, electronic funds transfer, and waiver of premiums or payment by check.
- Sets policy reserves and formulates dividend scales for each USGLI program based on the mortality experience and investment earnings of the funds.

VA will provide insurance coverage and services to Veterans who have lost their ability to purchase commercial insurance at standard (healthy) rates because of their service-connected disabilities. These include the Service-Disabled Veterans' Insurance (S-DVI) and the Veterans' Mortgage Life Insurance (VMLI) programs.

- Underwrites and issues USGLI policies to eligible disabled service-connected Veterans.
- Reviews and recommends VBA's position on legislation related to the insurance programs.
- Drafts legislative proposals.
- Prepares regulatory changes to implement new legislation and otherwise affect change.

- Develops, plans, and oversees implementation of new products designed to improve benefits and enhance Veterans' financial security.

VA will provide insurance coverage and services to Active-Duty and Reserve members of the uniformed services that are commonly provided by large-scale civilian employers. These include the Servicemembers' Group Life Insurance (SGLI) and the Veterans' Group Life Insurance (VGLI) programs, Family Servicemembers' Group Life Insurance (FSGLI) and Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI).

- Provides supervision, guidance, and direction to the Government-sponsored, commercially administered SGLI, VGLI, FSGLI, and TSGLI programs.
- Reviews and recommends VBA's position on legislation related to the insurance programs. Drafts legislative proposals.
- Develops, plans, and oversees implementation of new products designed to improve benefits and enhance Servicemembers', Veterans', and their beneficiaries' financial security.
- Determines appropriate premium rates for the SGLI and VGLI programs based on actual and projected program experience.

Authorities

38 U.S.C. Chapters 19, 21, 77

38 CFR Parts 6-9

Benefits Assistance Service (27)

Overview

The Benefits Assistance Service (BAS) serves as an advocate for Servicemembers, Veterans, eligible beneficiaries and other stakeholders, to ensure they are knowledgeable and informed about accessing and receiving VA benefits and services. BAS creates a consistent VBA message and provides oversight through all customer communication points for those who visit, call, write, or communicate with VBA online. The essential mission of BAS is to educate and create awareness among potentially eligible Veterans about the special programs created for their benefit.

Functions and Activities

BAS is the VBA outreach office and is charged with ensuring a strong VBA presence with a unified message across the nation. BAS is also responsible for collaborating with internal and external stakeholders to advocate for Veterans, Servicemembers and eligible beneficiaries to ensure they are knowledgeable and informed about accessing and receiving VA benefits and services. Moreover, BAS proactively researches and coordinates VBA outreach activities where they will provide the greatest return on investment, most closely align with emerging outreach demographics and most importantly increase access in support of VA goals.

- Serves as the lead outreach office for VBA with staff dedicated to synchronizing and integrating outreach activities throughout VBA and VA; activities, including coordination of advertising, social media, and web communications for outreach event across the nation.

- Conducts outreach to educate individuals, train employees, and train internal and external stakeholders.
- Represents VBA at national events and perform outreach activities to increase visibility and awareness of benefits available to Servicemembers, Veterans and family members.
- Facilitates targeted outreach campaigns to disseminate information about VA benefit programs.
- Coordinates with external governmental and nongovernmental agencies to produce better outcomes in the delivery of benefit services to Veterans.
- Conducts workshops and presentations at various outreach events to disseminate information and build relationships with stakeholders.
- Conducts outreach to Native American tribes and their members to increase awareness of VA programs.
- Leads outreach activities with external agencies that influence positive social and economic opportunity outcomes for Veterans such as housing, employment and various community resources.
- Recommends objectives and operations for new and existing outreach and direct services programs.
- Conducts site visits to evaluate outreach program management and operational processes for accuracy, consistency in service delivery and program integrity; develops and provides training based on site visit findings.
- Manages sustainment and enhancement of VBA IT outreach data tracking applications of the Federal Case Management Tool and the Outreach Submission Tool, which includes developing business requirements and conducting user-acceptance testing and associated processes to ensure acceptable system performance before deployment.
- Prepares policy and procedures in VBA Manual M27 to administer special emphasis outreach programs, direct services, and web communications.
- Develops and maintains VBA outreach publications to include fact sheets, pamphlets, and brochures.
- Directs the activities of the regional offices in actively engaging Servicemembers, Veterans, and their families to inform them about VA benefits and services.
- Assists local, state, and national partners with outreach activities targeted at specific Veteran demographics such as: minority, women, elderly, homeless, former prisoners of war, incarcerated, rural, faith-based, and Native American tribes.
- Coordinates with other federal agencies to provide benefits assistance and casualty assistance, the Overseas Military Service Program, the Transition Assistance Program (TAP), National Guard

Transition Assistance Advisors Program, Wounded Warrior Regiments, and the Yellow Ribbon Program.

BAS ensures quality by overseeing and training the seven National Call Centers (NCC) for the VBA toll-free number, the National Pension Call Center (NPCC), the National Inquiry Routing and Information System Response Center (NIRC), and the Regional Office Public Contact Teams (PCT).

- Develops and updates the National Training Curriculum, as well as refresher training materials for public contact representatives (PCR).
- Manages the administration of the Inquiry Routing and Information System (IRIS). Delivers training using various modalities, such as instructor-led and web-based.
- Develops and facilitates training for new, intermediate-level, and journey-level employees.
- Develops procedures, scripts, and job aids to provide employees with the information and guidance to appropriately respond to inquiries with accuracy and consistency at all access and touch points; to include telephone inquiries, inquiries through IRIS, chat inquiries, face-to-face interactions, and correspondence inquiries.
- Maintains the Knowledge Management System, which houses all source documents for the call centers/PCTs, in order to provide easy access to procedures and benefits services information.
- Oversees and manages customer satisfaction surveys to identify and develop process improvements.
- Monitors telephone calls and conducts quality reviews for telephone interactions, and IRIS to ensure PCRs disseminate accurate information to VBA customers and their dependents and comply with policies and procedures interactions.
- Facilitates call center and public contact team site visits to ensure that PCRs follow VBA policies and procedures.
- Provides training to call center managers, coaches, training coordinators, quality review specialists, and lead legal administrative specialists in the NCCs, NPCC, and NIRC to ensure they are knowledgeable of operations, benefits, services, policies, and procedures, and can effectively manage, coach, train, and mentor PCRs.
- Facilitates continuous improvement training sessions with members of the NCC management teams and the Office of Field Operations to identify best practices and areas for improvement, and drive NCC performance improvements.

The VBA Web Communications Office resides in BAS and is responsible for the following:

- Oversees and manages all VBA Internet and intranet content, to include the creation of new websites, application approvals, and maintain VBA's social media presence.
- Ensures all websites comply with federal mandates and agency rules and standards.

- Conducts periodic audits of website content and ensuring corrective action is taken.
- Provides web training and other customer-service-related training.
- Serves as the liaison for Web and social media inquiries and requests to the Office of Public Affairs, Office of Information Technology, and other VA entities.
- Authors content on the VBA home page and the home anterior pages.
- Manages social media content and policies.
- Manages eBenefits self-service, content authoring, and DS Logon on behalf of VA.
- Manages the Benefits.Gov program on behalf of VA.
- Manages the VBA GovDelivery account and service.
- Manages administration of the IRIS application.

BAS serves as VBA's liaison with our VSO and DoD partners.

- Facilitates partnerships with VSOs/stakeholders through recurring meetings and relationships to keep them apprised of VBA activities.
- Collaborates and partners with the DoD on numerous initiatives, task forces, and work groups to enhance benefits delivery and customer service.
- Collaborates with several Federal and state partners and community organizations to assist in the delivery of benefits and services, which may include critical and sensitive missions.

Authorities

38 U.S.C. §§ 306, 320 Chapters 20, 63, 77

38 CFR § 2.6(b)

Office of the Deputy Under Secretary for Economic Opportunity (20E)

Overview

The Office of Economic Opportunity (OEO) oversees the administration of benefits and services to Servicemembers, Veterans, their family members, and survivors. OEO aligns policies, procedures, and strategic priorities, and develops partnerships (i.e., schools, states, lenders, prospective employers) and interagency agreements (i.e., Department of Education, Department of Labor, and DoD) to promote economic opportunities for Veterans by providing access to education, vocational rehabilitation, employment, transition assistance, and home ownership.

Functions and Activities

OEO coordinates initiatives, projects, and procedural changes for Education Service, Vocational Rehabilitation and Employment Service, Loan Guaranty Service, and the Office of Transition, Employment, and Economic Impact.

- Develops and maintains tracking mechanisms to manage OEO program offices activities.
- Facilitates and monitors the implementation of new legislation and delivers results to VBA leadership.
- Coordinates and compiles data from OEO program offices for briefings to VBA leadership on activities and achievements.
- Works collaboratively with OEO program offices to ensure transformation initiatives are successfully executed and aligned with VBA objectives.
- Directs and oversees new initiatives, objectives, policies, and standards established to improve VBA services and programs.
- Develops and presents solutions to problems that affect day-to-day program management activities for OEO program offices.

OEO provides direction and input on policies, regulations, plans, procedures, guidance, and instructions necessary to implement and maintain effective operations that govern its program offices.

- Collaborates with VBA leadership in the development of new policies to ensure alignment with economic opportunity objectives.
- Develops performance measures and conducts performance reviews to assess the functional capabilities of program areas within OEO program offices.
- Reviews proposed legislation and executive orders to conduct long-range planning and evaluate immediate and long-term impacts on the fiscal, manpower and economic resources for OEO program offices.
- Recommends changes to current laws to enhance Veterans benefit programs.
- Communicates with OEO business lines and delivers strategic feedback to VBA leadership on proposed policy and procedural changes.
- Delivers guidance to business lines to ensure compliance with the objectives of VBA leadership.

OEO ensures that budgets and resources for OEO business lines are aligned to maximize outcomes.

- Identifies interconnecting OEO business line needs and allocates resources to improve service delivery to Veterans.
- Analyzes efficiencies and reassigns resources of OEO business lines to support achievement of major VA initiatives.
- Evaluates budgetary performance and develops planning mechanisms to forecast needs of OEO business lines.

OEO develops and implements strategy plans that create synergies and cross-collaboration among OEO business lines.

- Collects, interprets, and analyzes qualitative and quantitative data pertaining to business line activities and benefit administration.
- Identifies areas where synergies already exist or could be developed to maximize economic outcomes for Veterans.
- Creates and manages cross-functional work groups among OEO business lines to coordinate activities and enhance overall benefit delivery to Veterans.
- Ensures OEO resources are properly aligned to meet interconnected needs.

OEO leads activities with agencies that influence economic opportunity outcomes for Veterans.

- Coordinates with external governmental and nongovernmental agencies to produce better outcomes in the delivery of benefit services to Veterans.
- Leads VBA's efforts and provides staff support for multiple joint governing bodies and collaborate with other federal agencies on employment issues.
- Coordinates VBA responses to external requirements and mandates, such as those created by Congress.
- Represents VBA at national events and performs outreach activities to increase visibility and awareness of benefits available to Veterans, such as VA career fairs, small business conferences, VSO events, etc.
- Facilitates targeted outreach campaigns to disseminate information about OEO business line benefit programs and the services they provide.

Authorities

38 U.S.C. § 306 Chapter 77

38 CFR § 2.6(b)

Education Service (22)

Overview

The mission of Education Service is to provide educational assistance to Veterans and support all beneficiaries to achieve their educational, vocational and/or professional goals. Educational Assistance assists with the readjustment to civilian life; restores opportunities lost because of military service; extends higher education benefits to qualified persons who may not otherwise be able to afford it; aids military recruitment and retention of highly qualified personnel; and enhances the National workforce.

Functions and Activities

Education Service develops and implements regulations, other policy guidance, and procedures to translate legislation into the effective delivery of education benefits.

- Drafts proposed interim final and final regulations to govern new or modified education benefit programs.
- Develops and disseminates procedural guidance for processing, payment, and oversight of all VA education benefit programs.
- Proposes and maintains VA information collection requests with the Office of Management and Budget to facilitate processing of benefits and data collection from beneficiaries.

Education Service supports the Regional Processing Offices and Central Office staffs and some external stakeholders on VA education benefits and other relevant competencies.

- Analyzes training needs of staff and external stakeholders, such as School Certifying Officials and State Approving Agencies (SAA).
- Designs and develops training materials and manuals, including online training.
- Delivers training using appropriate methodology, such as train-the-trainer and Web-based training.
- Evaluates and reports training outcomes.

Education Service manages quality assurance, payment accuracy, program appraisal, internal control management, and equitable relief determinations.

- Conducts annual site visits at Regional Processing Offices and reviews a subset of education cases to determine accuracy.
- Monitors and reports field office workload and production.
- Provides direct customer service to beneficiaries on an ad hoc basis, and addresses congressional inquiries submitted to VA on behalf of claimants.

Education Service provides education and outreach on VA education benefits to internal and external stakeholders and beneficiaries.

- Conducts workshops and presentations at various outreach events to disseminate information and build relationships with stakeholders.
- Updates education benefit pamphlets, GI Bill website, GI Bill Facebook page, and other media.
- Disseminates information about VA education benefit programs and services.

Education Service develops effective education business line procedures and IT systems to support claims processing, and effectively implement statutes and regulations governing VA education benefits.

- Composes business requirements for Chapter 33 Long-Term Solution and other systems required for education benefit processing.

- Conducts user-acceptance testing and associated processes to ensure acceptable system performance before deployment.
- Updates M22-4 procedural manual as needed to support claims processing activities.

Education Service maintains, and enhances legacy systems to facilitate education benefit processing.

- Assesses existing legacy systems regularly and in response to program changes to ensure necessary functionality and identify any required modifications.
- Develops and submits project initiation requests to implement modifications or develop data reports for use by Education Service.
- Monitors system performance to ensure no interruption of claims processing.
- Education Service provides analytical support to enable the VA's mission and to meet customers' needs.
- Performs business analytics by evaluating, developing, and transforming ad hoc request into data-driven reports.
- Conducts qualitative and quantitative studies that support the strategies to meet customer needs.
- Oversees implementation of Executive Order 13607 – Principles of Excellence
- Manages outcome measures in collaboration with the Department of Education and Department of Defense in order to provide information on available educational programs to support informed decision making.
- Manages and facilitates Career Scope (assessment tool) to measure Veterans' interests and aptitudes to help them determine the best career path for transition to civilian life.
- Maintains reports.

Education Service maintains and enforces State Approving Agency (SAA) contracts and Yellow Ribbon Program agreements and serves as approval authority for education programs.

- Revises, issues, and processes SAA contracts annually to ensure maximum value to VA.
- Provides relevant training to and oversight of SAAs.
- Issues guidance and monitors performance of education compliance survey specialists.
- Supports the administration of the Yellow Ribbon component of the Post-9/11 GI Bill, which allows VA to enter into voluntary agreements with schools to cover beneficiaries' unmet educational expenses.

- Education Service maintains liaison and outreach activities with State Approving Agencies, School Certifying Officials, Veterans Claims Examiners and stakeholders.
- Provides supervision of Chief Education Liaison Officers (CELO). Provides supervision and guidance to Education Compliance Survey Specialists for the conduct of 100% audits, school liability, and OIG referrals.
- Oversees the conduct of quarterly quality reviews by education liaison representatives of compliance surveys conducted by the SAAs.
- Works with SAAs to establish their schedules and continued training.
- Compiles data about nature of discrepancies found during compliance surveys.
- Tracks results of compliance surveys and provides reports to leadership.
- Education Service manages the GI Bill Feedback System.
- Triage all incoming complaints and notify school of the complaint.
- Monitors response from the school and respond to Veterans.
- Makes determinations about the necessity of conducting a Risk Based Review and notifies CELO.

Collaborates with the OEO and aligns activities with LGY and VRE Service.

Authorities

38 U.S.C. Chapters 30, 32-36

38 CFR Part 21, Subparts B, C, D, G, H, K, P

P.L. 112-56

10 U.S.C. § 510

10 U.S.C. Chapters 1606-1607

Loan Guaranty Service (26)

Overview

The Loan Guaranty Service (LGY) maximizes the opportunity for Veterans and Servicemembers to obtain, retain, and adapt homes by providing a viable and fiscally responsible benefit program in recognition of their service to the Nation.

Functions and Activities

LGY provides a viable and progressive loan program as a benefit for eligible Veterans and Servicemembers to obtain homes.

- Increases the participation of private-sector program stakeholders and participants (i.e., lenders, builders, real estate agents, and appraisers) through varied communication/outreach activities and training sessions.

- Builds and enhances cross-cutting partnerships with private-sector trade groups (e.g., Mortgage Bankers Association), mortgage banks, and other Government agencies (e.g., the Department of Housing and Urban Development, DoD, and the Department of Treasury).
- Increases Veteran and Servicemember awareness of their home loan guaranty benefit through varied communication/outreach activities.
- Ensures that the collateral securing VA-guaranteed home loans meets VA's minimum property requirements.

LGY maximizes fiscally responsible opportunities for Veterans and Servicemembers to retain their homes or avoid foreclosure during times of financial hardship.

- Ensures VA has seamless access to life-of-loan information so that VA loan servicing staff can advocate for Veterans who are facing loan default.
- Forges partnerships across Government agencies to ensure unified Government response to VA borrowers in times of national emergency or economic crisis to ensure borrowers have maximized opportunity to retain their homes and avoid foreclosure.
- Works with private sector loan servicers to ensure that borrowers are offered a comprehensive set of financial options that could help them retain their home or avoid foreclosure (e.g., loan modifications, repayment plans, and deeds-in-lieu of foreclosure or short sales).
- Conducts outreach to Veterans, private-sector loan servicers and other industry stakeholders to ensure that VA remains at the forefront of the industry in offering home retention options and alternatives to foreclosure.

LGY adapts delivery of industry best practices and makes timely changes as necessary when technology or the marketplace generates improvements in the home loan process.

- In keeping with mortgage industry trends, LGY will undertake and support initiatives to ensure Veterans and other program stakeholders have secure, easy access to program information and benefit process information, and that they have the ability to interact with VA for benefits and services at a time and place that is convenient to them.

LGY effectively and efficiently administers the Specially Adapted Housing (SAH) grant program to enable eligible severely disabled Veterans and Servicemembers to live as independently as possible.

- Conducts initial interviews with Veterans and their families to explain the SAH grant benefit process and how it may be of assistance in meeting their disability-related housing needs.
- Conducts a feasibility inspection to determine if an existing home can be adapted to meet a Veteran's housing needs and SAH benefit requirements.
- Assists Veterans with locating and educating contractors/builders regarding SAH minimum property requirements and other accessible features.

- Conducts cost analysis and program oversight with desk and field reviews to minimize potential fraud, waste, and abuse due to misinterpretation of construction plans and contracts.
- Acts as a mediator to resolve complaints between Veterans and third parties involved with SAH program administration.

LGY provides direct-loan mortgage financing to Native American Veterans who desire to live on Federal Trust land.

- Conducts outreach to Native American tribes and their members to increase awareness of the program.
- Enters into memorandums of understanding that outline the rights and responsibilities of the respective Governmental entities.
- Funds direct loans to qualified Native American Veterans living on Federal Trust land.
- Conducts construction compliance inspections on new homes that secure Native American direct loans.

LGY ensures internal oversight of the home loan program is systematic and forward-looking, and ensures that program risks and internal controls are adequately assessed and monitored.

- Conducts audits/reviews of private-sector lenders, servicers, appraisers, and general contractors/builders to ensure they adhere to VA's laws, regulations, and policies for delivering the VA home loan guaranty benefit and program services.
- Conducts regular reviews of the work being done by Regional Loan Center staff (LoanSTAR, site visits, ad-hoc analysis, etc.) to ensure field stations are in compliance with VA's laws, regulations, and policies for delivering the VA home loan guaranty benefit and program services.
- Conducts thorough oversight/reviews of LGY contracts to ensure compliance with key contract provisions and to ensure that payments made to contractors are appropriate.
- Conducts regular and iterative internal control reviews and assessments of all LGY business processes so that all potential risks are identified, evaluated, and mitigated, as appropriate.

LGY markets VA-acquired properties for sale in a manner which maximizes return on investment to the Government and minimizes the time properties are held in inventory.

- Prepares properties for sale by inspecting, winterizing, and performing necessary repairs.
- Posts properties for market in a public manner.
- Manages properties that are in inventory to minimize potential damage and resultant cost to taxpayers.
- Has authority to offer VA-backed financing to qualified purchasers of VA-acquired properties.

LGY collaborates with the OEO and aligns activities with Education Service and Vocational Rehabilitation and Employment Service as appropriate.

Authorities

38 U.S.C. Chapters 30, 32-36
 38 CFR Part 21, Subparts B, C, D, G, H, K, P
 P.L. 112-56
 10 U.S.C. § 510
 10 U.S.C. Chapters 1606-1607

Vocational Rehabilitation and Employment Service (28)

Overview

The Vocational Rehabilitation and Employment (VR&E) program helps Veterans with service-connected disabilities and an employment handicap prepare for, find, and maintain suitable careers. for Veterans with service-connected disabilities so severe that they cannot immediately consider work, VR&E provides services to improve their ability to live as independently as possible.

Functions and Activities

VR&E develops and implements strategic and tactical plans to accomplish the mission as a component of VA's overall mission.

VR&E provides guidance and counsel to regional offices on a variety of issues impacting the VR&E program.

- Conducts monthly calls and provides corresponding newsletters to regional offices in order to ensure information is documented to ensure consistency.
- Maintains the Knowledge Management Portal (KMP), which centralizes all VR&E documents, to include the M28 Vocational Rehabilitation and Employment Procedures Manual, circulars, letters, and training materials. The KMP enables the VR&E regional office staff to operate within standardized guidelines.
- Develops and expands the Vocational Rehabilitation Counselor (VRC) Electronic Performance Support System (EPSS), an online reference, and information tool designed to enhance performance of VRCs by providing just-in-time work aids.
- Develops and deploys Training Performance Support Systems (TPSS) to ensure training is available and to ensure high performance and consistency in all job positions.

VR&E develops regulations and policies that drive effective and efficient processes.

- Conducts ongoing review of regulations to ensure that they result in the most effective delivery of vocational rehabilitation benefits.
- Develops and controls regulations to incorporate new laws or policies that impact the VR&E program.
- Develops legislative proposals for changes and improvements to the VR&E program.

- Reviews, analyzes, and prepares views and costing for legislative proposals initiated by other VA or other Federal organizational elements that may impact VR&E service delivery operations.
- Continues VR&E's Business Process Re-engineering (BPR), which will maximize Veteran self-service, counselor and Veteran tools, and simplify end-to-end processes for Veterans and professional staff. Updates corresponding metrics, quality assurance, and policy and procedures to support BPR changes.

VR&E formulates and executes the budget for the program.

- Formulates the budget for upcoming years based on current and future policies, legislation, and changing Veteran needs and demographics.
- Ensures budget focuses on core tactical and strategic goals in support of the Department's mission. Coordinates with ORM to finalize budgetary needs and assist in preparing the President's Budget.
- Monitors budget execution and adjusts budget as needed to meet emerging VR&E or VBA mission.
- Monitors and reports on the status of the general operating budget, funding of program, interagency agreements and service contracts.
- Administers national allocations to the Revolving Fund Loan (RFL) Program and the Educational Vocational (EdVoc) Fund.
- Reviews and processes all service contracts through the acquisitions' review staff.
- Ensures all acquisitions are in compliance with the acquisition process and support the Department's socioeconomic goals for small and disadvantaged businesses.

VR&E oversees regional outreach and service provision to Veterans.

- Provides quantifiable measures of the accuracy of decisions, procedures, and service provision in order to evaluate regional office performance.
- Conducts site visits to evaluate each VRE division's program management and operational processes for accuracy, consistency in service delivery, program integrity, and vulnerabilities to waste, fraud, and abuse of benefits.
- Conducts case reviews of a random sample of cases from each regional office on a monthly basis to evaluate for accuracy of decisions and provision of services.
- Identifies required actions for correction of errors and provides them to the Office of Field Operations and the appropriate regional office for action.
- Identifies trends in order to evaluate management, resource, system, policy, and training needs.

VR&E provides technical and advisory support to its divisions regarding regulations, policies, and procedures.

- Investigates and responds to a variety of program-related inquiries including Veteran, congressional, and all other stakeholder inquiries.
- Applies knowledge of current program legislation, policy, and rehabilitation trends to investigate, analyze and complete requests for administrative case reviews, advisory opinions, employee suggestions, or complaints.
- Makes recommendations to modify procedures, forms, and form letters based on regional office staff input.
- Establishes and maintains relationships with other VA service-level organizations and other Federal agencies, such as Department of Labor and Small Business Administration.

VR&E oversees staff training programs.

- Analyzes training needs of VA central and regional office staff to identify gaps and training needs related to the delivery of VR&E services. Develops a training plan that is comprehensive, clear, and that satisfies the needs for both novice and expert personnel.
- Develops leaders with well-planned training programs aligned with VR&E and VA business objectives and strategies for VR&E staff.
- Develops VACO staff by designing training programs tailored to the specific needs and function of VR&E service and the impact on the overall business line strategy and goals.
- Ensures delivery of training in multi-channel ways, taking advantage of technological advances.

VR&E implements and provides oversight of effective outreach programs to ensure Servicemembers and Veterans are provided with opportunities to participate in the VR&E program.

- Provides outreach and early intervention counseling services to transitioning Servicemembers through the Integrated Disability Evaluation System (IDES) program at 71 military installations.
- VR&E's VetSuccess on Campus (VSOC) program has professional vocational rehabilitation counselors located at 94 college campuses across the country. VSOC Counselors provide outreach, benefits assistance, professional counseling, and referrals for health care and other services to student Veterans, Servicemembers, and their eligible dependents.
- The VSOC program operates under VA's Educational and Career Counseling program, or Chapter 36 authority, which provides a wide range of educational and vocational counseling services designed to provide personalized counseling and support to help guide career paths, ensure the most effective use of VA benefits, and achieve educational and career goals to transitioning Servicemembers within six months prior to discharge, Veterans within one year following discharge from active duty, and all VA education beneficiaries.

- Coordinates and conducts effective outreach to special Veteran populations to increase participation and ensure successful outcomes.

VR&E communicates and establishes agreements with employers to connect job-ready Veterans with employment opportunities at the regional office level and oversees employment activities.

- Plans, coordinates, and participates in job fairs to promote the value of hiring VR&E program graduates and expose job-ready Veterans to potential employers.
- Reviews, assesses, and defines policy or program issues regarding employment services provided to Veterans with disabilities, and improving services to meet the employment needs of Veterans.
- Promotes the use of special hiring authorities, the special employment incentive programs, internships, and tax incentives to maximize employment of Veterans.

VR&E manages requirements for data to analyze performance metrics in support of Department goals.

- Analyzes existing data for organizational performance to ensure VR&E exceeds Veterans' expectations of quality, timeliness, and responsiveness.
- Enhances data reporting to support changing organizational requirements.
- Provides ad hoc and recurring reports to regional offices to assist in managing and overseeing regional office operations.
- Utilizes results to identify trends that necessitate changes in procedures and/or regional office training.

VR&E procures and governs contracts.

- Collaborates with the Center for Acquisition Innovation (CAI) and the OGC on the centralized acquisition and governance of VR&E service contracts.
- Provides guidance and training assistance to regional office VR&E managers and contracting specialists in the areas of contracting policy and procedures.
- Ensures the Department-wide Small Businesses, Small Disadvantaged Businesses, Women-Owned Small Businesses, Service-Disabled Veteran-Owned Small Businesses, Veteran-Owned Small Businesses, and Historically Underutilized Businesses are considered and documented in all VR&E acquisition packages.

VR&E continues to develop and refine effective IT systems.

- Develops and modifies requirements for existing and new IT systems to enable VR&E staff to meet and exceed Veteran expectations of quality, timeliness, and responsiveness.

- Develops Veteran-facing tools in collaboration with VRM to assist Veterans in maximizing self-service and expand access to tools that maximize success throughout the rehabilitation continuum.
- Updates tools that make policy, procedures, regulations, and training materials easily accessible to staff.

VR&E collaborates with OEO and aligns activities with Loan Guaranty and Education Service as appropriate.

- VR&E is in constant collaboration with Veterans Health Administration (VHA) and other federal, state, and private partners to provide Veterans the most comprehensive vocational rehabilitation services available.

Authorities

38 U.S.C. Chapters 1, 18, 31, 35, 36

38 CFR Part 21, Subparts A, C, D, M

Office of Transition, Employment, and Economic Impact (201D)

Overview

The Office of Transition, Employment, and Economic Impact (OTEEI) helps transitioning Servicemembers, Veterans, and their families maximize their economic competitiveness, defined as the ability to compete and remain relevant in a changing economy. Economic competitiveness encompasses overall employment, earnings, independent living, housing and educational attainment. To accomplish this, OTEEI seeks to educate transitioning Servicemembers, Veterans, and families on their VA benefits through strategic outreach and curriculum provided throughout their military life cycle (including while on active duty or in the National Guard or Reserve) and by developing strategic public and private partnerships, employment programs and place based strategies.

Functions and Activities

OTEEI works closely with the USB, PDUSB, COS, Office of Interagency Collaboration and Integration, and other federal agency officials to expand information-sharing and identify improvements in benefits information delivery and claim processing. OTEEI's specific focus areas include:

- **Pre-Discharge Program:** Has operational responsibility for cooperative disability compensation programs with VA and DoD. These responsibilities include the Integrated Disability Evaluation System (IDES); the Benefits Delivery at Discharge (BDD) program; the Quick Start Program; and policies related to Combat Related Special Compensation and Concurrent Retirement and Disability Pay.
- **Curriculum and Training:** Develops standardized VA curriculum and training programs to educate Servicemembers, Veterans, and their families on VA benefits, services, and partner programs. This includes the curriculum and training for the VA portion of the Transition Assistance Program, as well as military life cycle and other outreach events.
- **Transition:** Focuses on 100% participation in transition activities, such as the Transition Goals, Plans, Success (GPS) curriculum, throughout the military life cycle starting as a new

Servicemember and extending through to post-service as a Veteran. Collaborates and coordinates with interagency partners that provide related services and support.

- **Special Populations:** Works to understand and promote the unique needs of special populations, primarily the Guard and Reserve Servicemembers and Veterans, but also homeless Veterans, Women Veterans, and small cohorts of active duty Servicemembers such as Special Operations, to ensure improved economic outcomes.
- **Place-Based Strategy:** Increases the economic outcomes of local Veterans, improving collaboration between local community service organizations and VA, and mobilizing the private sector to hire and retain Veterans.
- **Veterans Employment Center:** Provided a single online resource that assists job seekers in skills translation, resume building, job search and connections with employers; and assists employers in posting jobs, making hiring commitments and connecting with job seekers. Further, provides a connection to comprehensive employment and career resources for both job seekers and employers.
- **Economic Development:** Facilitates and manages national-scale public-private partnerships with high quality organizations that are committed to improving the economic competitiveness of Veterans.
- **Skills and Education:** Improves the accessibility of existing tools and resources and increases the number of high quality opportunities in order to reduce the skills gap between military careers and meaningful civilian careers.
- **Employment:** Facilitates employer investments in Veteran economic opportunities including training, commitments, hiring and knowledge sharing.

Authorities

38 U.S.C. 77 § 306

38 CFR § 2.6(b)

Office of Field Operations (20F)

Overview

The Office of Field Operations (OFO) oversees operations at VBA's district offices, regional offices (ROs), the Records Management Center (RMC), the National Work Queue (NWQ), and the Appeals Management Center (AMC). Additionally, OFO oversees operations at satellite offices that are located in cities and districts with significant demand for benefits counseling. These operations consist of compensation and vocational rehabilitation claims and appeals processed at all ROs; pension claims, and appeals processed at the three pension management centers; housing benefits claims and appeals processed at the Regional Loan Centers at eight of the ROs; education benefits claims and appeals processed at the regional processing centers at four ROs; and Board of Veterans' Appeals (Board) remands and grants processed at the AMC.

Functions and Activities

OFO ensures that field offices deliver benefits and services to Veterans, Servicemembers, their families, and survivors effectively and efficiently.

- Reviews and evaluates management goals and objectives for VBA field and district offices, and helps develop achievable performance measures that ensure the quality and consistency of benefits delivery systems.

OFO facilitates performance and workload management for VBA's field offices.

- Ensures VBA benefits and services are provided in a timely, objective manner with respect to speed, accuracy, and customer satisfaction.
- Evaluates the performance of regional and district offices, and the AMC.
- Monitors, tracks, and evaluates national workload systems.
- Oversees employee development, and rewards and recognition programs.

OFO oversees resource management for VBA's field offices.

- Analyzes national field operations budget execution.
- Recommends nominations for centralized field positions to USB.
- Ensures VA-wide Small Business Program Goals for Small Businesses, Small Disadvantaged Businesses, Women-Owned Small Businesses, Service-Disabled Veteran-Owned Small Businesses, Veteran-Owned Small Businesses, and Historically Underutilized Business (HUB) Zone Small Businesses are considered in VBA acquisitions.

OFO oversees the VBA Operations Center (OC).

- Prepares, executes, and assesses the implementation of transformation initiatives, managing the project life cycle through a comprehensive Work Breakdown Structure and Critical Path methodology.
- Monitors and supports regional offices through an end-user hotline, which is open during normal business hours.
- Gathers and reports performance metrics to provide support for VA leadership decision-making.

OFO oversees NWQ.

- The NWQ office oversees the nationwide implementation of the new NWQ functionality for claims processing at all 56 Regional Offices.
- The NWQ staff, under the direction of the Deputy Under Secretary for Field Operations, is responsible for distributing workload from a centralized location based on the expertise of available resources at each location.

- NWQ provides VBA management with improved oversight and visibility of the claims processing on a national level and in real-time.

OFO ensures program and data integrity compliance at the field offices.

- Plans, develops, coordinates, and implements effective information security procedures as identified by OMB, the National Institute of Standards and Technology, VA policies, and VBA policy and guidance documents.

OFO provides the district offices, regional offices, RMC, and AMC with direction, guidance, and oversight when new and revised programs, policies, initiatives, and applications are implemented.

- Ensures policies, initiatives, and applications are implemented consistently nationwide.
- Monitors, tracks, and evaluates the cost and effectiveness of implemented changes.
- Provides senior leadership with feedback from the field.

OFO interacts with Veterans and national stakeholders.

- Communicates VBA policy, benefits programs, and procedures with national stakeholders (VSOs, Congress, VA, VHA, and public forums).
- Supports and assists audits and reviews conducted by the OIG, GAO, and others. Reviews and takes action on audit findings.

OFO oversees workplace and employee interaction.

- Promotes and maintains an effective labor-management relations program.
- Creates and maintains a working environment that is free of discrimination and assures diversity and inclusion in the workplace.
- Ensures that plans exist and are adequately implemented to recruit, select, train, coach, retain, motivate, empower, and advance employees; and promotes the needs and goals of the individual and the organization.
- Provides a safe, healthy work environment for employees.
- Develops, implements, and completes action plan methodology to address All-Employee Survey results.

OFO manages AMC:

- Supervises AMC, VBA's centralized processing center for appeals remanded by the Board.
- Monitors, tracks, and evaluates AMC's performance and workload.
- Partners with the Board to analyze and monitor remand trends.

OFO manages the National Capital Region Military Service Coordinators (MSC).

- Supervises VBA's Military Service Coordinators located at the Walter Reed National Military Medical Center.

Authorities

38 U.S.C. § 306, Chapter 77

38 CFR § 2.6(b)

North Atlantic, Southeast, Midwest, Pacific, and Continental Districts

Overview

Each District Office (20F1 thru 20F5) is responsible for the effective management of the VBA regional offices (ROs) for an assigned geographical area. The North Atlantic District Office is located in Philadelphia, PA, the Southeast District Office is located in Nashville, TN, the Midwest District Office is located in St. Louis, MO, the Continental District Office is located in Denver, CO, and the Pacific District Office is located in Phoenix, AZ.

Functions and Activities

- Monitors, tracks, and evaluates operations/workload indicators of the ROs within the area of jurisdiction.
- Provides direction, guidance, and oversight to ROs on implementation of new or revised programs, policies, initiatives, and applications.
- Regularly visits the ROs and meets with RO Leadership to ensure RO operations conform to all applicable laws, regulations, and established policies and procedures.
- Monitors and evaluates the performance of the Regional Office Directors.

Records Management Center (376)

Overview

The Records Management Centers in St. Louis, MO, receives and stores inactive claims folders and returns the folders to the ROs upon request. The RMC is also responsible for review, processing, storage, and distribution of Service Medical Records received from the Armed Services.

Functions and Activities

- Operates the VA Liaison Office at the National Personnel Records Center to process requests from regional offices for service data and service medical and personnel records needed to support claims adjudication on a national scale.
- Maintains BIRLS (Beneficiary Identification and Records Locator Subsystem) integrity, processes corrections to service data, and provides clerical support for 16 million claims folders.

- Furnishes service data and rating extracts to support eligibility inquiries from VBA, VHA, and NCA field offices and other branches of the government. Houses over 14 million claims files and over 2.8 million service medical records.

Appeals Management Center (397)

Overview

The Appeals Management Center (AMC) is responsible for the processing of appeals remanded by the Board of Veterans' Appeals (Board). A remanded appeal is an appeal that has been returned for development of additional evidence, due process, or reconsideration of issues.

Functions and Activities

- The AMC develops the remand, makes decisions based on evidence gathered, and authorizes payment of benefits.
- If the AMC is unable to grant an appeal in full, the AMC re-certifies it to the Board for continuation of the appellate process.

Office of Management (20M)

Overview

The Office of Management (OM) directs and oversees VBA's Headquarter Offices of Employee Development and Training, Acquisition, Administration and Facilities, Human Resources, and Employee Engagement, Diversity & Inclusion.

Functions and Activities

OM ensures that policies, concepts, and strategic approaches in offices under its jurisdiction are successfully implemented in support of VBA's Veterans benefits programs and services.

- Advises VBA and Departmental officials on problems involving the relationship of work performed in OM with respect to its impact on broader programs.
- Liaises with the Department on issues regarding services and programs under the supervision of the OM.
- Recommends to the Under Secretary for Benefits plans, policies, regulations, procedures, standards, and legislation for VBA-wide application.
- Serves as a member of VBA's Executive Resources Board, Performance Review Board, and several senior-level task forces at the Departmental level.
- Serves as the Head of Contracting Activities for VBA.

Office of Human Resources (20M1)

Overview

The Office of Human Resources oversees policy development, procedures and programs for VBA's nationwide HR activities.

Functions and Activities

- Provides effective, efficient, direction, control, and operation of VBA nationwide programs and services through coordination with the Human Resource Centers.
- Ensures appropriate policies and plans exist to recruit, retain, and advance VBA employees.
- Ensures the successful execution and maximum use of human capital management principles and resources at all organizational levels.
- Leads VBA national labor negotiations with the Mid-Term Bargaining Committee.
- Manages the area of telework, suitability, drug-free workforce programs, and succession planning.
- Develops and provides HR training in all areas to employees and management.

Office of Administration and Facilities (20M3)

Overview

The Office of Administration and Facilities oversees policy development and procedures for VBA's activities in the areas of emergency preparedness, facilities and space management, environmental and materiel management, Privacy Act, Freedom of Information Act (FOIA), fleet management, mail management, forms management, publications, printing, directives, WARMS, web management, Equipment Inventory Listing (EIL), custody and movement of Veterans' records and acquisition of service Department records needed to process Veterans' claims.

Functions and Activities

- Provides effective, efficient, economical direction, control, and operation of VBA nationwide programs and services.
- Manages the areas of capital investment planning, privacy and security, and equipment inventory listing.
- Oversees VBA occupational safety and health program, forms, and records management, directives and publications, FOIA, privacy and VA Web management.
- Administers VBA's space management program for nationwide procurement and utilization of space and the design of modern office systems and environments.

- Leads the VBA emergency management and physical security programs in response to emergencies and disasters to reduce property loss, maintain public safety, and preserve continuity of benefits and services to Veterans and their families.
- Administers VBA's Freedom of Information Act and the Privacy Act to ensure the right of access to Federal Department records as required by law.

Office of Acquisition (20MA)

Overview

The Office of Acquisition (OA) serves program customers by ensuring timely, cost effective, and compliant acquisitions to enable the VBA mission.

Functions and Activities

- Provides acquisition policy guidance and advice to all VBA customers. Establishes standard operating procedures to ensure uniformity and compliance of the acquisition process and products.
- Develops and monitors various reports to ensure compliance and quality, and conducts regularly scheduled and unscheduled audits.
- Establishes annual operating plan to manage and monitor the VBA's small business program and serves as national VBA Small Business Liaison.
- Responds to periodic Inspector General and Department audits and other requests for information.
- Serves as the national VBA Coordinator for Electronic Contract Management System and Federal Procurement Data System.
- Monitors continuing professional education of Federal Acquisition Certification in Contracting.
- Implements and oversees VBA contracting requirements.
- Serves as the approving authority for field and Central Office warrant holders. Terminates appointments of warranted individuals as necessary.

VBA Office of Acquisition (Regional Teams)

Overview

Five teams aligned with the Office of Field Operations' North Atlantic, Southeast, Midwest, Pacific, and Continental Districts provide operational acquisition support to VBA regional offices. In addition, the teams assist with VBA Central Office procurements not supported by the VACO Office of Acquisition Operations.

Functions and Activities

- Primarily supports the Office of Field Operations and Vocational Employment and Rehabilitation programs.
- Each supervisor serves as the District Small Business Liaison.
- District leads for eCMS and FPDS.

Acquisition Support Team

Overview

Provides a broad range of services to customers who utilize the assisted acquisition services located in Frederick, MD.

Functions and Activities

Services include:

- Reviews all acquisition packages for completeness and compliance.
- Processes all acquisition packages to obtain VBA concurrence/approval.
- Coordinates approved acquisitions with the appropriate contracting office (CO) staff to ensure contracts are awarded on time.
- For all central office acquisitions, prepares, tracks, and provides training and coordination for all aspects of background investigation process including the Security Investigation Center.
- Receives, reviews, and processes invoices from the Office of Resource Management (ORM) that have been submitted to the Austin Automation Center for payment to ensure amounts requested are proper.

Authorities

Federal Acquisition Regulations (FAR)

VA Acquisition Regulations (VAAR)

Office of Employee Engagement, Diversity & Inclusion (20M2)

Overview

The Office of Employee Engagement, Diversity & Inclusion (EEDI) ensures VBA's compliance with VA policies and directives, laws, executive orders, and other provisions designed to foster a harmonious workplace that is free from discrimination and promotes a diverse workforce committed to delivering quality care and services to our Nation's Veterans, Servicemembers, family members, and survivors.

Functions and Activities

- Supports the VA Office of Resolution Management (ORM) in processing Title VII EEO complaints filed by employees and applicants who allege employment discrimination.
- Processes Title VI discrimination complaints filed by students against proprietary schools referred by - ORM in accordance with VA's delegated agreement with the Department of Education, Department of Justice , and the Department of Health and Human Services.
- Processes external Title VI discrimination complaints filed by Veterans that are referred to EEDI by ORM.
- Manages VBA's Alternative Dispute Resolution Program in compliance with the EEOC's regulations.
- Coordinates and provides EEO, diversity, and inclusion training and guidance to employees, managers, and supervisors and serves as VBA's internal subject matter expert on issues involving EEO, diversity and inclusion.
- Drafts and updates policies and strategic plans in accordance with current laws and needs of the organization.
- Submits compliance reports and plans annually.
- Manages VBA's Summer Internship Program and oversees VBA's Special Emphasis Program commemorating special historical events and the contributions of ethnic groups and individuals.

Office of Employee Development and Training (20M5)

Overview

The Office of Employee Development and Training ensures that VBA develops, implements, and evaluates innovative learning programs and practices that promote a systematic and comprehensive approach to training, and develops VBA employees in order to provide quality, seamless service to Veterans.

Functions and Activities

- Provides learning and training program development services to VBA employees.
- Provides technical training development and support and evaluation services to VBA employees. Integrates training requirements from VBA field offices and business lines.
- Provides VBA employees with leadership and professional development programs and opportunities and manages the VBA Professional Development Academy in Baltimore, MD.
- Manages VBA's portion of the Talent Management System (TMS) to analyze and prioritize VBA's requirements for training for each fiscal year.

- Manages recurring training reports and develops appropriate ad hoc reports to meet emergent needs as identified by leadership.
- Creates and distributes standardized templates and job aids to promote the application of training best practices throughout VBA.
- Provides tailored leadership development services and programs to VBA field and HQ offices and lines of business.

Authorities

38 U.S.C. § 306, Chapter 77

38 CFR § 2.6(b)

5 U.S.C.

The Equal Pay Act of 1963

Civil Rights Act of 1964, Title VI and Title VII as amended

Age Discrimination in Employment Act (ADEA) of 1967

No Rehabilitation Act of 1973, as amended by the American Disability Act Amendments Act of 2008

Notification and Federal Employee Antidiscrimination and Retaliation (No FEAR) Act of 2002, as amended in 2009

Federal Acquisition Regulations (FAR)

American with Disabilities Act (ADA) of 1967

P.L. 109-461

Office of Resource Management (24)

Overview

The Office of Resource Management (ORM) helps VBA serve Veterans, employees, and taxpayers by effectively obtaining and accounting for financial and other resources, and by effectively planning and measuring results.

Functions and Activities

ORM provides cost estimates, monitors transactions, and ensures accurate obligations and execution of funds for VBA:

- Formulates VBA's general operating expense budget for all business lines, Staff Offices, and field operations.
- Oversees obligations, providing detailed information about the VBA spending and ensuring proper management of funds.

ORM develops, prepares, and justifies all mandatory budget estimates necessary to support Veteran's benefits requirements.

- Submits estimates and justifications to the appropriate parties (VBA, VA, OMB, and Congress) over the course of the budget cycle.
- Provides cost estimates for new and amendatory legislation, and briefs senior officials in VBA, OMB, and Congress about matters concerning the mandatory benefits budget.

- Plays a distinct role in the distribution of funds pertaining to benefit payment activities.

ORM manages and directs all budgetary activities involving the VBA housing, insurance, and vocational rehabilitation programs.

ORM provides support to VBA Headquarters staff and VBA regional offices for all finance activities, including payroll, travel, Government purchase card and benefits questions.

- Develops and issues formal policies and procedures.
- Implements business process improvements, including Treasury initiatives.
- Develops, implements, and supports fiscal systems (VETSNET, CWINRS, etc.) that support programs that deliver benefits.
- Prepares and submits new system business requirements, including the review and approval of functional specifications documents leading to user acceptance testing and the associated coordinating of implementation with other VBA and VA organizations.

ORM manages and directs activities involved with ensuring the integrity of VA's financial accounting, reporting, and systems for VBA activities.

- Prepares and submits VBA financial statements and other reports, including the Improper Payment Report.
- Researches and corrects accounting errors.
- Ensures that current policies and procedures for programs are implemented.
- Provides detailed accounting business requirements and system testing support to the Finance Services Fiscal System staff.
- Serves as the primary liaison with financial statement auditors and ensures internal control reviews are accomplished.
- Serves as the VBA point of contact for all audit remediation efforts as well as the primary liaison for financial system inspector general activities.

Authorities

38 U.S.C. § 306 Chapter 77

38 CFR § 2.6(b)

Administrative and Loan Accounting Center (241A)

Overview

The Administrative and Loan Accounting Center (ALAC), located in Austin, Texas, provides financial management support to VA's administrative accounting and housing programs by performing accounting, financial reporting, voucher examining, payments, budget support, verification,

recertification, reclamation, limited payability, and financial advisory services for these national operations.

Functions and Activities

ALAC performs Loan Guaranty Accounting for VBA.

- Oversees payment and collection processing, including payments for acquisitions, claims, property sales, and management expenses.
- Reviews LGY financing accounts general ledgers, and performs general ledger and subsidiary records reconciliations as well as system reconciliations to include the SF-224 Statement of Transactions reconciliation.
- Manages vendor receivables and processes all deposits for noncash collections, Lender Appraisal Processing Program (LAPP) fees, and Servicer Appraisal Processing Program (SAPP) fees.
- Processes and reports portfolio loans, transitional housing, loan sales, and Native American Direct Loans (NADL).
- Provides audit support to VBA's Office of Resource Management for internal control audits and financial statement audits.
- Collaborates with VBA's Loan Guaranty Service and VA's Office of Information Technology in the development of automation processes for the loan guaranty and payment systems.
- Provides advice and makes recommendations to program officials concerning all aspects of the financial management including reporting and analysis; conducts special, routine, and periodic reviews and audits of the general ledger processing systems.

ALAC performs administrative accounting for VBA.

- Processes financial transactions for VBA regional offices nationwide. The transactions include budget, obligations, payments, receivables, deposits, accruals, advances, and cost adjustments.
- Reviews VBA financial transaction processing and management system reports for regional offices, VBA management, VACO, and oversight agencies.
- Reviews VBA regional office general ledger accounts and performs general ledger and subsidiary ledger reconciliations.
- Provides oversight and tracking of VBA regional offices aged accounts, including undelivered orders, federal advances, suspense, and accounts receivable.
- ALAC manages VBA's National Finance Training Strategy (NFTS) and training and coordinates internal ALAC training classes.
- Designs, develops, and implements finance-specific, technical training modules for VBA's support services/financial management community.

- Collaborates with VBA's Office of Management, Office of Facilities and Administration, to design, develop, and deliver administrative-specific, technical training modules for VBA's support services community.
- Oversees VBA's Support Services Council (SSC).

ALAC manages VBA's Regional Office Management Assistance Program (ROMAP).

- Assists VBA regional office management in confirming corrective action to address audit findings and assists VBA regional office staff with VA guidance and instruction on management control over finance areas.
- ALAC manages VBA's Centralized Administrative Accounting Transaction System (CAATS).
- Ensures all CAATS system and software design and development functions are carried out appropriately.
- Liaises with VA contracting, information technology (IT), project management (PM), systems testing, independent validation and verification (IV&V), contractor, and other business line staff and management to confirm milestone achievement for application design and development.
- Generates appropriate systems documentation, and oversees / reviews this documentation for consistency across development phases, to authenticate completion of required milestones, and to ensure programmatic adherence to VA's project management / systems lifecycle design approach.

Authorities

38 U.S.C. § 306 Chapter 77

38 CFR § 2.6(b)

VBA Finance Center (241e)

Overview

The VBA Finance Center (VBA FC) in Hines, IL provides accounting, financial reporting, and fiscal services related to the payment of benefits to Veterans and beneficiaries.

Functions and Activities

The VBA FC provides direction and oversight for VBA:

- Manages all financial and accounting operations for VBA benefit program payments and any related returned funds. These programs include compensation, pension, and education. Assists and/or establishes regional office policies and procedures related to benefit payments and returned funds.
- Manages various accounting and fiscal transactions, and coordinates the utility of financial programs and systems with Hines Information Technology Center (ITC).

- Ensures that officials at the Treasury Regional Financial Centers are informed of scheduling requirements relative to VA benefit payments.
- Manages the maintenance of an internal control network for all benefit payment systems ensuring the reliability and accuracy of the accounting and fiscal data that process through the systems.
- Facilitates Office of Inspector General, Independent Audit and Government Accountability Office personnel in their performance of financial and system audits.
- Serves as liaison for all benefit payment audit documentation requirements.

The VBA FC manages benefit accounting and payment certification for VBA:

- Ensures that all control and subsidiary accounts are reconciled and in balance allowing for the timely certification of all Veterans benefits program payments worldwide.
- Monitors and coordinates the processing of various accounting/fiscal transactions with various internal VA and external Federal agencies, including the Hines ITC, VA Central Office, VBA Office of Resource Management, the Department of Treasury, the Department of Defense, and the Department of Homeland Security.
- Provides technical advice and assistance in establishing and interpreting procedures and improvements to the benefit accounting data processing runs.
- Prepares end-of-month/end-of-fiscal-year trial balance reports for each benefit payment program. Prepares monthly statements of transaction reports for all systems.
- Ensures funding availability in all benefit programs and manages the execution of benefit payment funding.

The VBA FC processes and controls recertification/limited payability transactions and entitlement/non-entitlement claims, and the interfacing of same within the benefit payment systems:

- Apprises VACO and Treasury Department personnel of issues, problems, and the status of initiatives in progress, and provides technical advice to VBA regional office personnel concerning all phases of the recertification process, including the establishment of credits/debits into the payee benefit master records.
- Establishes and implements procedures for processing check cancellations, payment over cancellations, reclamations, reclamation collections, limited payability, and annual reporting fees.
- Prepares correspondence to payees and VBA regional offices regarding chargeback items, and responds to payee inquiries, VBA regional office personnel, and Treasury Department employees regarding status of claims.

- Operates and maintains the “Access” database, Recertification Accounting and Tracking System application and the Benefits Delivery Network Recertification database. VBA-FC also processes and reviews accounts regarding expenditure transfer items from the Treasury Department.

Authorities

38 U.S.C. § 306 Chapter 77

38 CFR § 2.6(b)

Office of Performance Analysis and Integrity (20B)

Overview

The Office of Performance Analysis and Integrity (PA&I) develops and maintains the Enterprise Data Warehouse to generate recurring and ad hoc reports in response to VBA decision making and business needs. PA&I promulgates and posts reports displaying the operating data in the most insightful graphics possible. PA&I analyzes the data and provides VBA managers with the situational awareness needed to optimize their operating and business functions. PA&I coordinates all VBA-related OIT and GAO audits and reviews.

Functions and Activities

PA&I performs data and information services for VBA:

- Keeps the Enterprise Data Warehouse (EDW), which is populated with the data marts that are most used and of the greatest value for VBA business intelligence needs. It eliminates combines or retires the data marts that are dormant while identifying data sets that could be and should be added or enhanced because of their recognized value.
- Manages the configuration of the EDW to simplify and optimize data access and reporting, including an approach to adding new data sets to the warehouse in a rational and repeatable way.
- Develops and maintains a 5-year plan that estimates how the EDW will grow in storage and back-up requirements, when technology refresh will be required, as well as what new technology or process will need to be incorporated into the EDW.
- Develops a technology refresh and acquisition plan in conjunction with OIT for EDW hardware and software and for the business intelligence tools needed to display reports.
- Develops a formal process with written procedures that describe receipt, triage/evaluation, risk assessment, prioritization, status tracking, quality assurance, and delivery of data products and services.
- Delivers the product for all data requests within 45 working days. It achieves 95-percent accuracy in the delivered data, reports, and services as defined by the customer requirements or business rules.

PA&I provides performance analysis services for VBA:

- Maintains an ongoing process to ensure that posted reports are of greatest use and value, eliminates dormant or low-value reports, and revises or combines existing reports to enhance their use and value.
- Ensures timeliness and accuracy in posted and delivered reports and services as defined by customer requirements or business rules.
- Develops and sustains the capability to address the analytical needs of VBA leadership and field activities.
- Coordinates preparation and submission of VBA's Annual Benefits Report and VBA's input into the Monthly Performance Review and VA's annual Performance and Accountability Report.
- Organizes, plans, and hosts at least one Introductory and one Advanced Management and Program Analyst Workshop a year to provide the opportunity for field and headquarters analysts to enhance their skills.
- Facilitates analytical and performance management training on a recurring and as-needed basis that increases the overall analytical capability of the organization using the tools and analytical techniques of the most value.

PA&I provides program integrity and internal controls services for VBA:

- Coordinates all activities associated with GAO engagements and VA Inspector General audits within VBA.
- Ensures VBA leadership is aware of the status and likely outcome of activities associated with external oversight reviews and audits.
- Coordinates the preparation and delivery of VBA responses to oversight reports, requests, and analyses to ensure accurate, on-time submission with language acceptable to all parties.
- Maintains an up-to-date Master Oversight Review calendar that external auditors can use to coordinate their planned activities with VBA field offices.

Authorities

38 U.S.C. § 306 Chapter 77

CFR § 2.6(b)

Veterans Health Administration

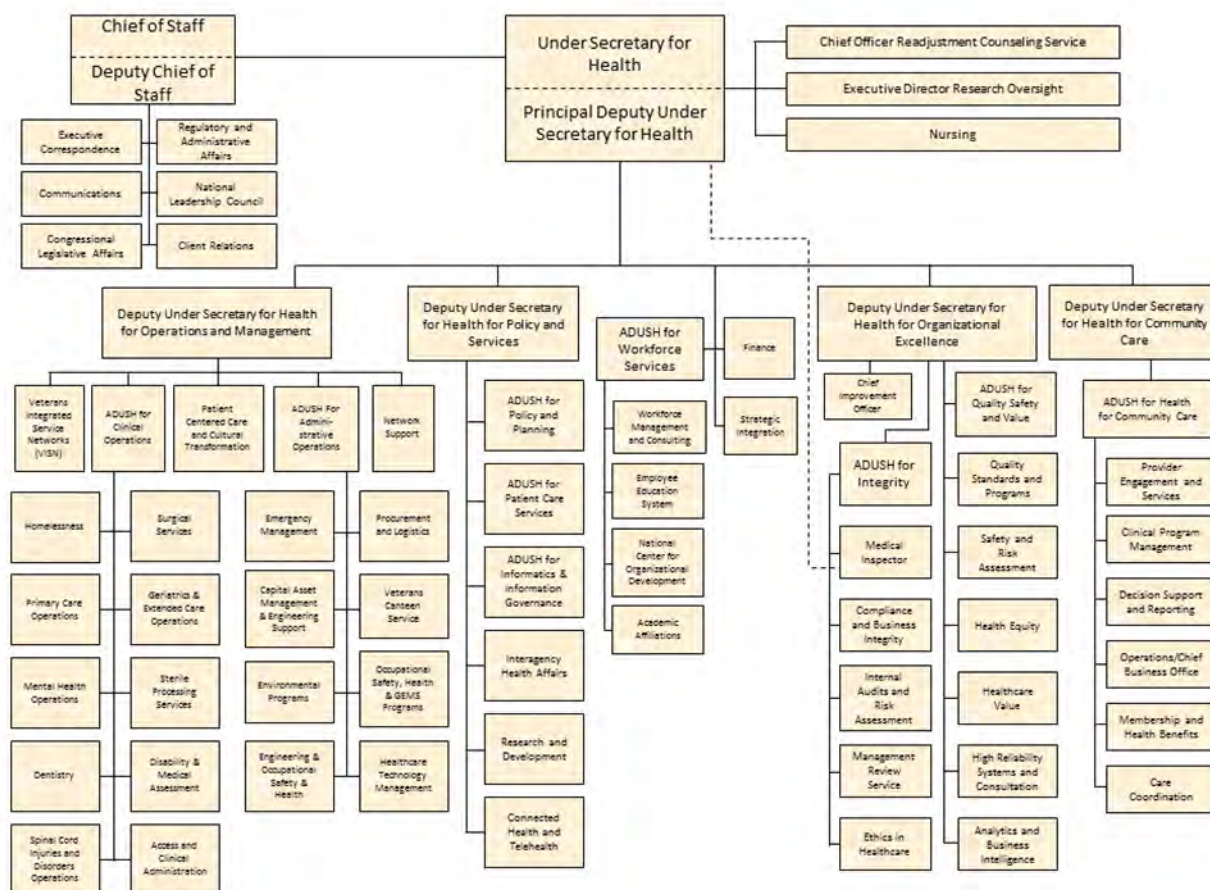


Figure 12 - Veterans Health Administration Organization Chart

[Click here for the alternate representation of the chart](#)

Office of the Under Secretary for Health

Mission

To honor America's Veterans by providing exceptional health care that improves their health and well-being.

Overview

The Office of the Under Secretary for Health (USH) is responsible for the leadership and direction of VHA, the Nation's largest integrated health care system. The four statutory missions of VHA are: 1) to develop, maintain, and operate a national health care delivery system for eligible Veterans; 2) to administer a program of education and training for health care personnel; 3) to conduct health care research; and 4) provide contingency support for DoD and Department of Health and Human Services (HHS) during times of war or national emergency.

Functions and Activities

- Leads VHA in defining corporate code of ethics, vision, principles, policies, goals, expectations, and the lines of authority through which these will be actualized.
- Communicates VHA's vision, principles, policies, goals, expectations, and outcomes to the Office of the Secretary, other VA departmental officials, Members of Congress, Veterans, Veterans Service Organizations (VSOs), other Federal agencies, and external stakeholders.
- Establishes committees, advisory groups, and review bodies as necessary to provide information and advice to the USH.
- Oversees formulation and execution strategies of VHA policies and budgets, and serves as chair of various boards, committees, and working groups.
- Establishes standards, policies, and positions regarding national workforce issues.
- Develops VHA policies that provide equal treatment of Veterans through the most cost-effective means. Fosters innovation, creativity, and informed risk-taking.
- Establishes policies that monitor the quality of health care with a goal of being a leader in the field of health care delivery.
- Promulgates and communicates policies that articulate VHA's role in national health care reform initiatives.
- Establishes and/or approves standards for VHA research programs, capital asset planning and management, and information management.
- Recruits, trains, and employs personnel for occupations that are specific to the needs of the Veteran population.
- Establishes affiliation agreements with academic institutions across the country to support the educational needs of health care professionals.
- Establishes and/or approves standards for VHA's research program in biomedical research, mental health research, prosthetics, and other rehabilitative research and health care services research.
- Establishes research oversight policies to monitor, review, and investigate matters of medical research compliance and assurance of safety.
- Provides contingency support for Department of Defense (DoD) and The Department of Health and Human Services (HHS) during times of war or national emergency.
- Establishes policies and designates resources related to medical services, crisis intervention, and emergency preparedness.
- Establishes policies that support the National Disaster Medical System and promotes sharing resources with other Federal agencies and community partners.

Authorities

Title 38 U.S.C. Chapter 73

P.L.97-174

Veterans Administration and DoD Health Resources Sharing and Emergency Operations Act, 1982

Title 38 U.S.C. § 8011A

Veterans Access, Choice, and Accountability Act of 2014 (VACAA)

Office of the Chief of Staff**Overview**

VHA Office of the Chief of Staff (COS) works closely with the Under Secretary for Health and the Principal and Deputy Under Secretaries in managing the day-to-day operations of VHA, the largest integrated health care system in the country. The COS serves as VHA's central coordination point for all high-level negotiations involving establishment or implementation of policies, practices, management, and operational activities to carry out the mission of VHA. The COS manages VHA's executive correspondence, communications, congressional and legislative affairs, regulations, client service relations and the National Leadership Council (NLC), which is VHA's governing body.

Functions and Activities

- Coordinates and responds to all requests for information from the Department and the White House.
- Coordinates and responds to all requests for information from external stakeholders, such as Congress, Veterans Service Organizations (VSOs), other Governmental agencies, and the general public.
- Ensures VHA's message is clear, concise, and consistent with VA's current position and strategic direction.
- Works closely and effectively with partners throughout the Department including but not limited to the Office of the Secretary of Veterans Affairs (OSVA), Office of Management (OM), Office of Government Relations (OGR), Office of Public Affairs (OPA), Office of General Counsel (OGC), and Office of Policy and Planning (OPP).

Authorities

38 U.S.C. 73

P.L. 97-174

Veterans Administration and DoD Health Resources Sharing and Emergency Operations Act, 1982

38 U.S.C. § 8011A

Veterans Access, Choice, and Accountability Act of 2014 (VACAA)

Office of Executive Correspondence**Overview**

Under the leadership of the Director, the Office of Executive Correspondence administers the correspondence management program for the VHA. 10B1 houses the Under Secretary's official files, establishes VHA correspondence policy, and provides writing, research, and other administrative support on correspondence matters, including conducting and arranging a variety of training sessions.

10B1 staff reviews all correspondence for the signature of the Secretary and Deputy Secretary of Veterans Affairs, Under Secretary and Principal Deputy Under Secretary for Health, and conducts a daily mail review to present those items that are ready for signature or for forwarding for higher level VA signature.

Functions and Activities

- Provides timely and accurate responses to inquiries from Congress and affiliated offices (Congressional Budget Office, Congressional Research Office, etc.), as well as Veterans, Veterans' family members, and the general public.
- Provides accurate responses to Congress, the White House, VSOs, other Federal agencies, the media, and the public on a wide variety of system issues, both proactively and in response to inquiries.

Office of Communications

Overview

The Office of Communications (OC) provides communications counsel and expert advice to the Office of the Under Secretary for Health. OC determines strategies and methods to be used in informing Veterans, stakeholders, and employees about the policies, programs, actions and initiatives at the Veterans Health Administration (VHA).

OC provides internal and external communication capabilities enabling VHA leadership to communicate messaging supportive of the patient-centered VHA mission of delivering superior health care to America's Veterans. Key components of the OC program include voluntary service, national concert series, communication product development, media prep and interviews, advertising, VHA history, web management, social media, graphic design and speechwriting. OC leverages these skills to deliver messaging that enable VHA's top leaders to communicate their vision and ideas in a clear and accurate manner to inspire confidence and drive results.

Functions and Activities

- Creates and maintains a consistent VHA communications strategy and message throughout all 10B2 products.
- Regularly assesses the communications structure/process to determine which methods work best, how employees and stakeholders perceive important messages, and reliability of communications systems.
- Ensures development and promulgation of policies, standards, guidelines and procedures to facilitate coordination of VHA Communications and public affairs.

Office of Voluntary Service

Overview

Office of Voluntary Services (10B2A) builds and leverages the advocacy of Veterans Service Organizations (VSO), and provides supplemental services to Veterans through the utilization of

volunteer and in-kind resources from Veteran, civic and other community organizations in support of the VA mission.

Functions and Activities

- Manages the largest volunteer program in the federal government.
- Builds and leverages volunteers for the support and execution of VA programs.
- Through the use of volunteer and in-kind resources from Veteran, civic and other community organizations, provides supplemental services to Veterans in support of VA's mission.

Office of Media Operations and Plans

Overview

Office of Media Operations and Plans provides proactive media relations and communication planning, and provides external communication capabilities that enable VHA leadership to strategically communicate messages that support the patient-centered VHA mission of delivering superior health care to America's Veterans.

Functions and Activities

- Provides communication counsel and advice to senior VHA leaders.
- Communicates policies, programs, actions and initiatives across VHA via traditional media (newspapers, radio, and television).
- Regularly assesses the communications structure/process to determine which tools work best, reliability of communications systems, whether messages are received as intended, and how employees and stakeholders perceive important messages.

Office of Digital Media

Overview

Office of Digital Media oversees VHA's online presence, web content, social media, graphic design and limited video capability.

Functions and Activities

- Coordinates Internet, Intranet, and social media content development and management for VHA Central Office program offices and field Veteran Integrated Service Networks and VA Medical Centers.
- Develops and implements strategies that maximize the effectiveness of web and social media communication across VHA to connect with key stakeholders.

Authorities

38 U.S.C. §301

Office of Congressional and Legislative Affairs

Overview

The VHA Office of Congressional and Legislative Affairs (OCLA) serves as the principal advisor to the Under Secretary for Health on congressional and legislative matters affecting VHA. VHA OCLA is responsible for preparing VHA leadership and subject matter experts for congressional hearings and briefings, responding to congressional inquiries, tracking legislation, reviewing congressional correspondence, monitoring and clearing congressional report submissions, overseeing implementation of public laws and guiding the development of VHA's legislative proposals.

Functions and Activities

- Develops an effective legislative program for VHA initiatives, and provides advice and assistance to VHA program offices regarding legislative program and congressional liaison activities. VHA Legislative staff prepares the largest internal legislative proposal package in VA's portfolio each year.
- Manages VHA's involvement in congressional hearings. Develops, reviews, and edits written testimony; analyzes issues related to the hearing; develops briefing materials and conducts pre-hearing briefings to prepare VHA witnesses; and arranges external meetings and reviews testimony from other Departments or agencies.
- Responds to Congressional inquiries, pre- and post- hearing questions, and deliverables resulting from hearings and briefings. Routinely monitors congressional and legislative activities that might impact VHA operations, and advises VHA leadership on viable courses of action.
- Tasks, oversees, and provides concurrence on all VHA reports that arise from the annual Congressional appropriations legislation as well as other Congressionally-mandated and Congressionally-tracked reports.
- Develops VHA's position on documents prepared by other government departments and agencies, e.g., draft bills, enrolled enactments and other referrals of a legislative nature forwarded through the VA Office of General Counsel or VA Office of Congressional and Legislative Affairs.
- Collaborates with VHA subject matter experts to develop responses to questions from Members of Congress or Committees; monitors congressional liaison activities by reviewing and clearing documents leaving VHA, assisting with congressional meeting preparation, and performing other support functions.
- Reviews proposed Executive Orders, regulations, and directives for consistency with current law and VHA policy.

The Office of Regulatory and Administrative Affairs

Overview

The primary mission of ORAA is to ensure that all VHA regulations and policy documents (directives, handbooks, etc.) are drafted clearly, comply with applicable legal and technical requirements, and are published in a timely manner. The office also provides services related to collections of information

from the public covered by the Paperwork Reduction Act; maintains or supports national databases of VHA policy documents and forms that are used by internal and external stakeholders; and publishes VHA official forms and informational documents (e.g., posters, brochures).

Functions and Activities

- Drafting all VHA regulations in close coordination with VHA program offices and VA Office of General Counsel (OGC).
- Shepherding VHA regulations through the two to three year process of review and revision within VA, and obtaining appropriate review and comment from external stakeholders, the Office of Management and Budget (OMB), and the public.
- Assisting VHA program and field offices in securing OMB approval for collections of information covered by the Paperwork Reduction Act, which includes hundreds of regulations, official forms, customer service questionnaires, oral or written surveys or research tools, and other devices.
- Designing certain VHA publications and forms and assisting in the publication of same.
- Maintaining national forms and VHA policy publication databases on the intra- and internet.
- Working closely with VHA program offices and OGC in developing national policy documents signed by the Under Secretary for Health (e.g., directives, handbooks) to ensure compliance with applicable legal, procedural, and technical requirements, and ensuring that these documents continue to be updated every five years as required by VA policy.
- Assisting in developing regulatory strategies to respond to new legislation and responses to inquiries from Congress or the public concerning regulatory matters.

Authorities

38 U.S.C. 301

National Leadership Council Office

Overview

The National Leadership Council (NLC) is the Under Secretary for Health's governance structure for all policies, plans, and procedures across the entire Veteran Health Administration (VHA) system. The Office of National Leadership Council functions as a focal point for VHA's support for organizational processes central to support senior leadership decision-making. The Office of National Leadership Council is responsible for developing, implementing, and monitoring the support structure and procedures to facilitate VHA's primary governance council.

The NLC consists of senior VHA leaders including those with the Office of the Under Secretary for Health, each Veterans Integrated Service Network (VISN) Director, and select VHA Chief Officers. The NLC comprises seven Council Committees (Strategic Directions, Workforce, Healthcare Delivery, Healthcare Quality & Value, and Veteran Experience, Resources, and Information Technology) and 13 NLC subcommittees.

Functions and Activities

- Reviews and assesses all current and revised VHA policy and procedures specifically as they relate to VHA governance.
- Administers and analyzes assessments for the NLC, which are presented to the Executive Leadership Team for further action.
- Coordinates policies and procedures related to operations and management of the NLC, and assists in the development of national guidance to use in implementing these policies, as well as conducting evaluations of these policies to identify needed modifications.
- Reviews, processes, and tracks all Executive Decision Memorandums (EDMs) for VHA, which receive final approval by the Under Secretary for Health, and maintains an online database to record and track all EDMs for the organization.
- Provides guidance to over 30 NLC points-of contact on fulfilling their responsibilities.
- Develops strategic plans and short and long-range goals for the NLC and seven NLC committees.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV.

Office of Client Services Response Team

Overview

The VHA Office of Client Services Response Team (CSRT) serves to centralize and streamline internal processes to improve VHA's overall responsiveness to concerns of Veterans, employees, and other internal and external stakeholders. The VHA Client Services Relations Team (CSRT) works closely with VA and VHA program offices and facilities to review, research and respond to inquiries sent to the Office of the Under Secretary for Health, VHA related inquiries sent to the Office of the Secretary and other concerns and another inquires that are received via Program Offices within VACO which lack a formalized response process.

Functions and Activities

- Works collaboratively with internal and external customers at all levels of the organizations to achieve successful resolutions, to simplify internal coordination, and enhance the customer service experience.
- Provides management and oversight for all VHA Client interest inquiries generated from emails, phone calls, facsimile, letters, special interest correspondence, and seeks to understand and establish a customer service culture to promote strategies to meet and/or exceed customer needs and expectations.
- Coordinates the customer service experience by ensuring that timely and accurate responses are provided to VHA Client Inquiries, and when appropriate, corrective actions taken.

Office of Readjustment Counseling Services

Overview

The Office of Readjustment Counseling Services (RCS) Vet Centers is a service within the Veterans Health Administration that consists of 300 Vet Centers, 80 Mobile Vet Centers, and the Vet Center Call Center (877-WAR-VETS). The primary mission of RCS is to welcome home war Veterans, active Duty Service members, and their families with honor, and provide three major service functions: outreach, readjustment counseling, and referral for those individuals and their families. Vet Centers are VHA community facilities that treat each individual as a whole person in or near his or her home community.

Readjustment Counseling Services are authorized by legislation (38 U.S.C. 1712A) to be separate from VHA health care and they employ different eligibility criteria. The eligibility criteria for Vet Centers include Veterans and active duty Service members, to include members of the National Guard and Reserve components, who have served on active military duty in any combat theater or area of hostility; experienced a military sexual trauma; provided direct emergent medical care or mortuary services, while serving on active military duty, to the casualties of war; or served as a member of an unmanned aerial vehicle crew that provided direct support to operations in a combat zone or area of hostility. Eligibility also extends to Vietnam Era Veterans who have accessed care at a Vet Center prior to January 1, 2004.

Vet Center services are also provided to family members of Veterans and Service members for military related issues when it is found aid in the readjustment of those that have served. This includes bereavement counseling for families who experience an active duty death. Services do not require enrollment for VHA medical care and are provided regardless of character of discharge, to include service provision to individuals with problematic discharges. The RCS Chief Officer reports to the Under Secretary for Health and is responsible for direct line supervision of the Vet Centers through the seven RCS regional managers. Additional information is available at http://www.va.gov/directory/guide/vetcenter_flsh.asp.

Functions and Activities

- Vet Centers provide individual and group readjustment counseling to assist combat Veterans and Service members in resolving war-related trauma and readjusting to civilian life.
- All Vet Centers maintain regularly scheduled non-traditional hours, to include evening and weekends and provide professional individual and group counseling services by VHA-qualified mental health professionals, many of whom are also Veterans, as well as family counseling for problems related to the Veteran or Service member's combat experience.
- Vet Centers provide community outreach and education to help combat Veterans and Service members overcome barriers to include brochures, public service announcements, and presentations in numerous settings to educate local service providers and civic leaders about military-related issues, combat theaters, Veterans' service needs, and VA services and benefits available to meet those needs.
- Vet Centers provide direct outreach to engage Veterans and Service members in a personal way that minimizes bureaucratic formality and helps the individual overcome stigma and barriers to care. The Vet Centers' Veteran-to-Veteran peer model is critical in helping Veterans overcome stigma and combat-related avoidance tendencies.

- Vet Centers provide assessment and referral for other needed services to include substance abuse, mental health, and medical problems; employment services; explanation of and referral for VA benefits; assessment, counseling and referral for Military Sexual Trauma; and bereavement counseling for surviving family members of Service members who died on active duty.
- RCS maintains a fleet of 80 Mobile Vet Centers (MVC) that are designed to extend the reach of Vet Center services through focused outreach, direct service provision, and referral to communities that do not meet the requirements for a “brick and mortar” Vet Center, but where there are Veterans, Service members, and their families in need of services. In many instances these communities are distant from existing services and are considered rural or highly rural. The placement of these vehicles is designed to cover a national network of designated Veterans Service Areas (VSA) that collectively covers every county in the continental United States, Hawaii, and Puerto Rico.
- Each MVC includes confidential counseling space for direct service provision as well as a state of the art satellite communications package that includes fully encrypted tele-conferencing equipment, access to all VA systems, and connectivity to emergency response systems. Vet Center staff regularly collaborates with VA partners to create a single VA Footprint at events to ensure access to all available VA services and benefits.

Authorities

38 U.S.C. 1712A

P.L. 96-22 § 103

P.L. 111-163 § 401-402

P.L. 112-239 § 727-728

P.L. 113-146 § 402

38 CFR Part 17 RIN 2900 AN92 and 2900 AP21

68VA15

Office of Research Oversight

Overview

The Office of Research Oversight (ORO) promotes the responsible conduct of research, serves as the primary VHA office in advising the USH on matters of research compliance, and exercises oversight of compliance with VA and other Federal requirements for the protection of human research subjects, laboratory animal welfare, research safety, research laboratory security, research information security, research misconduct, and Government-wide debarment for research impropriety. P.L. 108-170, enacted December 2003 and codified at Title 38 U.S.C. 7307, established ORO in statute to report directly to the USH and stipulated ORO’s oversight authority as independent of the Office of Research and Development (ORD) and any other VA components that administer or fund VA research.

ORO develops research oversight policy and provides direct oversight of all VA research activities related to human subject protections, laboratory animal welfare, research safety, research laboratory security, research information security, research misconduct, Government-wide suspension and debarment for research impropriety, Research Compliance Officer (RCO) audits, and RCO education. All VA research is conducted through research programs at VA medical centers and Program Offices.

Functions and Activities

- Advises the USH on all matters of regulatory requirements in research.
- Investigates suspected impropriety, regulatory noncompliance and misconduct in VA research.
- Receives and investigates reports of transgressions in VA research.
- Oversees the conduct of onsite compliance reviews.
- Oversees the implementation of remedial actions where warranted.
- Ensures the procedural integrity of research misconduct reviews and investigations.
- Monitors serious adverse events in VA research.
- Tracks the cause of all unanticipated deaths in VA research.
- Oversees training of VA's facility-based Research Compliance Officers (RCOs).
- Provides technical assistance to VA research programs.
- Disseminates regulatory information to the broader VA research community.
- Maintains an anonymous complaint line that is monitored daily.
- Provides oversight of the VA Central Office Human Research Protection Program and the VA Central Institutional Review Board (IRB).

ORO Review Management and Integrity Workgroup

Overview

The Review Management and Integrity Workgroup (RMI) manages ORO's onsite review program and oversees research misconduct investigations in VHA facilities.

Functions and Activities

- Prioritizes ORO onsite reviews based on risk and vulnerability assessments, facility needs and availability, and ORO staffing resources.
- Advises facilities regarding research misconduct allegations, inquiries, investigation, and reporting.
- Assesses quality of ORO onsite reviews to ensure consistency, accuracy, thoroughness, and appropriate documentation.

ORO Comprehensive Research Oversight Workgroup

Overview

The Comprehensive Research Oversight Workgroup (CROW) within the Office of Research Oversight is responsible for conducting Comprehensive Program Reviews (CPR) at all VA research facilities. The

CROW also has oversight for General Research Administration issues (including Research and Development Committee (R&DC) issues) and serves as Facility Liaisons to all VA facilities with research programs.

Functions and Activities

- Obtains a comprehensive **Overview** of a facility's research compliance program in order to assess any areas of vulnerability.
- Provides on-site focused review, for cause review, or technical assistance for issues related to General Research Administration and the R&DC.
- Provides review and follow up of any noncompliance findings related to General Research Administration and the R&DC.
- Serves as "permanent" "primary or back-up" facility liaisons to facilities to facilitate communication among subject matter workgroups assuring assistance and resolution to inquiries and issues.

ORO Research Information Security Program

Overview

The Research Information Security Program (RISP) within the Office of Research Oversight assists VHA research programs in enhancing and improving their facility Research Information Security Programs so that Veteran research subjects' personal information and other VA research data are appropriately protected.

Functions and Activities

- Conducts onsite Information Security Focused Reviews of all VHA facility research programs.
- Remotely manages reports of Information Security incidents.
- Provides remote and onsite Technical Assistance to VA research programs as needed.

ORO Research Safety and Animal Welfare Program

Overview

The Research Safety and Animal Welfare (RSAW) Program within the Office of Research Oversight assists VHA research programs to enhance and further improve the safety of research workers and the environment, the physical security of research facilities, and the welfare of laboratory animals.

Functions and Activities

- Conducts onsite Focused Reviews of VA facility Research Safety and Security Programs (RSSP) and Animal Care and Use Programs (ACUP).
- Partners with VHA research programs to resolve noncompliance and other unexpected events involving research safety, laboratory security, and laboratory animal welfare.
- Provides Technical Assistance to VA research programs as needed.

ORO Policy and Education Program

Overview

The Policy and Education group within ORO provides education and support for facility Research Compliance Officers (RCOs) and coordinates guidance on policy affecting ORO operations.

Functions and Activities

- Conducts remote and onsite Focused Reviews of RCO auditing programs.
- Provides national teleconferences for RCOs, self-study guides for new RCOs, and face-to-face regional and national RCO education and training meetings.
- Provides Technical Assistance to VA research facility RCOs as needed.
- Reviews, contributes to, coordinates, and publishes policies/guidance affecting ORO's operations.
- Maintains a Policy Archive of policy-related questions.

ORO Informatics and Data Analytics

Overview

The Informatics and Data Analytics group within ORO is responsible for developing and implementing a risk-based model to support ORO's compliance activities. The IDA group also oversees VHA research Quality Improvement (QI) activities.

Functions and Activities

- Collects and analyzes relevant and available data related to facility research programs and oversight.
- Develops a profile of each research facility's capacity to oversee research compliance.
- Administers the annual Facility Directors Certification of Research Compliance.

ORO Human Research Protection Program

Overview

The Human Research Protection Program (HRPP) assists research protection programs at VHA facilities to ensure the protection of human subjects participating in VA research and the effective oversight of the research program by the facility.

Functions and Activities

- Conducts onsite Focused Reviews of facility Human Research Protection Programs (HRPP).
- Monitors the remediation of non-compliance in human research.
- Provides Technical Assistance to VA research programs as needed.

- Oversees facility Federal wide Assurances and IRB Registrations and Memoranda of Understanding.

Authorities

P.L. 108-170 § 401

38 U.S.C. 7307

Office of Nursing Services

Overview

The Chief Nursing Officer (CNO) is the senior advisor to the Under Secretary for Health and to key VHA and Department officials on all matters relating to VA Nursing and the delivery of patient care services. The CNO also acts as consultant to Program Office, Veterans Integrated Service Network (VISN), and facility leadership in planning strategic activities. ONS collaborates inter-professionally to enhance and support evidence-based professional practice, workforce research and education, and the VA nursing workforce to strengthen leadership and teamwork in order to provide quality, patient-driven care for the Nation's Veterans.

Functions and Activities

- Develops and executes the VA Nursing Strategic Plan through four work streams focusing on clinical practice, research and evidence-based practice, workforce and leadership, and policy, education and legislation.
- Consults with Program Office Veterans Integrated Service Network (VISN) and facility leadership in planning strategic activities necessary to support quality patient care, access, cost effectiveness, staff and patient safety, nursing recruitment, retention, professional development, and customer satisfaction.
- Provides oversight for the VA Central Office Nursing Professional Standards Board.
- Collaborates with and advises VHA program offices VISN staff, facility leadership teams, nurse executives, professional organizations, congressional offices, consumer groups and stakeholders to address complex health care delivery and nursing practice issues at a national level.

Clinical Practice

Overview

Clinical Practice establishes systematic approaches to support efficient and effective patient-centered care in all setting and programs.

Functions and Activities

- Adopts patient-centered nursing care delivery models that prepare for future practice environments, populations, technologies, and workforce designs.
- Consults and recommends practices to improve Veteran access to care through national inter-professional initiatives and recommends evidence-based practices across specialties for nursing and in collaboration with inter-professional partners.

- Supports national initiatives to improve patient safety and quality as demonstrated through clinical sensitive indicators, including pressure ulcer prevention throughout VHA.
- Fully implements and provides expert recommendations regarding innovative nursing practice through Nursing roles including RN care managers and other nursing representatives in Patient-Aligned Care Teams (PACT), Advanced Practice Registered Nurses (APRN), and Clinical Nurse Leaders as well as nursing models of care such as Shared Medical Appointments, Nurse Practitioner-led teams, and using virtual and telehealth to improve access and efficiency.
- Adopts new technology through mobile applications to streamline nursing practice, documentation, and patient education.
- Addresses the needs of special populations such as the polytrauma needs of returning OEF/OIF/OND Veterans, supporting efforts to care for senior Veterans, creating innovative care coordination for homeless Veterans, and advocating for the use of population health management across all populations of Veterans.
- Advocates for and implements full practice authority for APRNs, including Certified Registered Nurse Anesthetists (CRNA), Clinical Nurse Specialists (CNS), and Nurse Practitioners (NP), to facilitate consistent APRN practices across states and enhance patient access.

Nursing Research and Evidence-Based Practice

Overview

Nursing Research creates and facilitates a culture of inquiry to improve health care delivery and outcomes throughout the VA. The goal of the Nursing Research program is to develop capacity for high-quality research by nurses to inform nursing science and evidence-based practice, thereby promoting health and excellence for Veterans.

Functions and Activities

- Increases nursing research capacity through annual grant-writing workshops for novice nurse scientists, mentoring of nurse scientists, bi-monthly teleconferences with the VA nursing community, and an updated Nurse Scientist Toolkit and Business Case.
- Partners with the Office of Research and Development as grant application reviewers, serves as member of quality enhancement research initiative (QUERI) Research and Methods Committee, and QUERI Steering Committees, and with the ONS Centers of Evaluation.
- Disseminates and monitors achievements of VA nurse researchers (publications, presentation, and grants), and provides a directory of VA nurse scientists and EBP champions.
- Collaborates with the Office of Research and Development/Million Veterans Program to create and roll out five genomic nursing online modules.

Evidence-Based Practice Program

Overview

Evidence-Based Practice Program (EBP) facilitates infrastructure development to ensure VA nurses consistently engage in an evidence-based practice to improve health care delivery and outcomes throughout VA.

Functions and Activities

- Conducts ongoing education for direct care nurses and nurse leaders in basic principles of evidence-based practice and the EBP process of identifying and implementing evidence-based interventions. Education includes:
- Basic EBP Process Workshop for EBP mentors.
- Evidence-Based Leadership Workshop for nursing leaders.
- Advanced EBP Infrastructure Workshop for EBP Program leads.
- Provides, through the Evidence-Based Practice EBP Consultation Service, a facility assessment, recommendations, and follow-up to facilitate infrastructure development that supports a culture of evidence-based practice.
- Updates and expands the EBP Resource Center hosting EBP curricular modules, videos, business case, and an electronic roadmap that guides project teams through a systematic, rigorous process to identify and implement evidence-based interventions.
- Develops TMS genetics and genomic TMS modules to increase Registered Nurse competencies.

Workforce and Leadership

Overview

Workforce and Leadership ensures a competent, dedicated, compassionate, and high-performing nursing workforce through retention, recruitment, and organizational initiatives, and prepares nurse leaders for the future.

Functions and Activities

- Leads the national implementation of the Staffing Methodology for nursing personnel and provides consultation and training to facilities and VISNs to support successful implementation and monitoring of the Staffing Methodology.
- Promotes board certification for specialty nursing.
- Leads and manages the Central Office Nursing Professional Standards Board and provides consultation and training to facilities to support Nurse Professional Standards Boards, Licensed Practical Nurse Professional Standards Boards, and Nursing Assistant Professional Standards Boards.
- Advises and supports the implementation of the Travel Nurse Corps.

- Develops and implements mentoring program for nurse executives.
- Partners with the Office of Academic Affiliations to develop and support nurse transition/residency programs.
- Develops programs and training to provide comprehensive nursing services to Veterans, and address national emergency response plans for local, state, Veterans Integrated Service Network (VISN), and national needs.
- Provides a nursing consultation program that offers VISN, facility, and VACO-level consultation for the purpose of developing and supporting nurse leaders, particularly in response to resolving high-priority, high-risk leadership issues.

Policy, Education, and Legislation

Overview

Policy, Education, and Legislation ensures that input is provided for all proposed relevant national policy, initiatives, and activities that impact nursing practice delivery.

Functions and Activities

- Reviews all VHA draft policy and guidance and provides consultation and input related to nursing practice and health care for Veterans.
- Consults with and advises VHA program offices VISN staff, facility leadership teams, nurse executives, professional organizations, congressional offices, consumer groups and stakeholders to address complex health care delivery and nursing practice issues at a national level.
- Partners with the Office of Academic Affiliation on the design, development, implementation, and monitoring of academic strategies and initiatives related to the discipline of nursing.
- Develops legislative initiatives that support the organization's vision, mission, and goals for nursing practice.
- Represents VHA at national, regional and Federal health care organizations.
- Analyzes issues and develops national nursing strategies that foster effective labor management partnerships and workforce diversity goals.
- Provides national oversight with the Office of Community Engagement for the Intermediate Care Technician Program, including the Corpsman and Medic Vocation Education Training (CAMVET) Program pilot.

Authorities

38 U.S.C. 73 and applicable subchapters I-IV

P.L. 79-293

P.L. 98-160

P.L. 107-135

P.L. 111-163

Office of the Principal Deputy Under Secretary for Health

Overview

The Office of the Principal Deputy Under Secretary for Health (PDUSH) ensures the integration, effectiveness, and reliability of the systems and programs supporting the health and well-being of our Nation's Veterans. In the absence of the USH, the PDUSH performs the duties of the USH. PDUSH collaborates with the Deputy Under Secretary for Health for Operations and Management (DUSHOM), the Deputy Under Secretary for Health for Policy and Services (DUSHPS), the Deputy Under Secretary for Health for Care in the Community and the Deputy Under Secretary for Health for Organizational Excellence to provide leadership, guidance and strategic direction in support of the mission of the USH and VHA.

The Office of the PDUSH comprises three program offices that are critical to the mission of VHA: the Office of the Assistant Deputy Under Secretary (ADUSH) for Health for Workforce Services, The Office of Finance and the Office of Strategic Integration. Additionally, the Office of the PDUSH provides oversight and coordination assistance to the Office of Nursing Services and Readjustment Counseling Services.

Functions and Activities

- The PDUSH acts as the immediate assistant to the USH in daily administrative duties and is responsible for the integration of programs and policies across VA's National health care system.
- Provides oversight and guidance for chief officers, network directors, and program officials in VACO and National health care facilities.
- Leads VHA in defining the corporate code of ethics, vision, principles, policies, goals, expectations, and the lines of authority through which these will be actualized.
- Establishes or approves standards for VHA research programs, emergency care, capital asset planning and management, and information management.
- Provides innovative and forward-looking fiscal investment planning, programming, and budget execution oversight throughout VHA. Develops policy, program initiatives, and management requirements that align with the VA strategic plan and enterprise wide solutions.
- Represents VA and VHA on several executive committees, including the Central Institutional Review Board for VA research initiatives; the National Action Alliance for Suicide Prevention; the National Priority for Patients with Health and Human Services and the National Quality Forum.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV

Office of the Assistant Deputy Under Secretary for Health for Workforce Services

Overview

The Office of the Assistant Deputy Under Secretary for Health (ADUSH) for Workforce Services facilitates the Veterans Health Administration's (VHA) ability to develop, recruit, and retain a skilled, highly qualified workforce that keeps VHA out front as a world-class health care system. To achieve VHA's mission, it is essential that VHA is prepared to recruit and retain skilled, dedicated, and high-performing

employees, as well as develop a talented succession pipeline. The ADUSH for Workforce Services recognizes that employees are VHA's most critical asset and is committed to achieving individual and organizational high performance. The goals of the ADUSH for Workforce Services are driven by VA and VHA missions, strategic goals, objectives and strategies.

Effective relationships and synergies among workforce management, employee development, education, academic affiliates, and organizational development are promoted with collaborative efforts through Workforce Management and Consulting (WMC), Employee Education System (EES), National Center for Organization Development (NCOD), Healthcare Leadership Talent Institute (HLTI), and the Office of Academic Affiliations (OAA).

Functions and Activities

- Responsible for all elements of human capital management within VHA.
- Supports the integration of policy, operations and oversight for more than 312,704 VHA employees and more than 120,000 trainees in areas including human resources, training, education and professional development.
- Responsible for advancing VHA's strategic position on personalized, proactive and patient centered health care delivery and clinical workforce management.
- Conducts ancillary work to support the operational performance of VHA through both coordination and direct service delivery to the field in the areas of human resources, education, training, employee and organizational development.
- As change drivers, serves Veterans and the long-term development of people and culture to address future challenges as VA continues its transformation into a 21st century organization.
- Provides consultation to leaders at all levels of VA to improve organizational health, including consultation on change management, resilience, virtual teams, executive team building, engagement, psychological safety, and other factors relevant to developing leaders and engaging employees.
- Oversees VHA succession and workforce planning; identifies and monitors talent needs and trends within the organization, and links succession planning and business strategies, presenting VHA with the opportunity to reach long-term goals and achieve human capital objectives.

Workforce Management and Consulting

Overview

Workforce Management and Consulting (WMC/10A2A) provides VHA-wide leadership for workforce operations and administration management functions, including strategic human capital planning; senior executive recruitment and performance; senior-level advisory services; labor management and labor relations; retention and recruitment; training and career development; and retention of a highly skilled, motivated, and effective workforce.

Workforce Management and Consulting (WMC) provides VHA-wide leadership for workforce operations and administration management through strategic human capital planning, senior executive

recruitment, performance and advisory services, labor management and labor relations, and training and career development. WMC ensures the recruitment and retention of a highly skilled, motivated, and effective workforce and provides advice and assistance to VHA leadership on human resources issues. A key architect in the development of new legislation, policies, and programs, WMC also ensures that VHA maintains its position as a leader in the health care industry.

Functions and Activities

- Provides staffing, recruitment, employee-labor relations, classification, and retirement and benefits support to the VA health system, and designs, develops, and implements training and development programs for VHA's professionals.
- Manages the recruitment and nomination process for VHA executive-level positions; advises senior-level executives, field and program offices about human resource (HR) issues and provides advice and guidance concerning conduct and performance issues involving senior-level executives in VHA.
- Provides advice and assistance to VHA leadership on human resources issues through HR Development Retention and Policy; also responsible for the planning, direction, control, coordination, operation, education and evaluation of the VHA HR program to include the development of new legislation, policies, and programs to ensure that VHA maintains its position as a leader in the health care industry.
- Manages the Executive Career Field Performance (ECF) Management Process for Senior Executives within VHA, and manages the organization's employee awards program; the development of HR competencies in VHA HR field staff, as well as HR competencies for VHA supervisors.
- Provides advice and assistance on employee labor relations issues to include 7,422 decisions; and administers a variety of employee scholarship and clinical education programs for VHA.
- Supports VHA's workforce through HR administration, performance management, recruitment and retention, and employee development; also provides administrative, financial, and logistical oversight for all VHA headquarters Program Offices and staff, and operates the VHA Employee Transit Benefits Program and the National Child Care Center Program.
- Focuses on strategic workforce planning and addresses anticipated gaps in the hiring of physicians, and other clinical staff, through the operation of the National Recruitment Program and professional marketing outreach. Recruits executive level positions in VHA Central Office, and the field, and serves as the VHA's Delegated Examining Unit.
- Through the Equal Employment Opportunity /Affirmative Employment Office (EEO/AEO), provides guidance on EEO/AEO regulations and assists management in creating and maintaining a work environment based on the principles of EEO – trust, dignity, respect, and removal of barriers to enable employees to achieve their highest potential.
- Advances diversity, cultural competency and inclusion within VHA through the VHA Office of Diversity and Inclusion (ODI). The office supports the VA Diversity and Inclusion Strategic Plan through programs that focus on patient-centric health care delivered by engaged teams.

Employee Education System

Overview

The Employee Education System (EES/10A2B) has a headquarters function in Washington, DC, and ten field-based offices located in: Birmingham, Alabama; Cleveland, Ohio; Crystal City, Virginia; Little Rock, Arkansas; Long Beach, California; Minneapolis, Minnesota; Northport, New York; Orlando, Florida; Salt Lake City, Utah; and St. Louis, Missouri. EES supplies training solutions to achieve the goals and objectives of VHA's strategic plan. Operationally, EES partners with clients in VHA's program offices, Veterans Integrated Service Networks (VISNs) and medical facilities to provide quality workforce education and training to improve outcomes in Veteran clinical care, health care operations and administration. The collaborative EES client services model produces comprehensive training needs assessments and facilitates rapid development and delivery of innovative, high-quality learning.

Active portfolio management of client training projects helps EES allocate VHA training capacity against organizational priorities and to broadly leverage existing learning programs and products. EES's use of "ADDIE model" instructional design process – Analyze, Design, Develop, Implement, and Evaluate – represents a closed loop approach for building training that fully addresses the effectiveness and efficiency of training solutions. EES training and education programs provide core accredited content needed by staff to maintain licensure and certification. EES also develops specialized learning content to equip VHA's health care providers with the most current knowledge and skills to address the challenging needs unique to a Veteran patient population.

Functions and Activities

- EES co-leads VHA's Learning Organization Transformation (LOT) effort, which aligns health professions training, staff education and workforce development within the VHA employee lifecycle model.
- EES works to integrate VHA and VA workforce education and training efforts, including cross-cutting training, knowledge management and learning delivery and infrastructure initiatives.
- Leads successful efforts to establish processes and tools to manage and oversee VHA compliance with new VA requirements for conference approvals, reporting, and oversight.
- Promotes the use of non-face-to-face Learning Options, and is increasing the percentage of all VHA programs that are delivered virtually.
- EES holds 15 national and 3 state accreditations/approvals for continuing education in the healthcare professions.
- Evaluates every learning program against identified learning and performance objectives in order to establish clear links between training interventions and improved workplace operations.
- Through the Simulation Learning Education and Research Network (SimLEARN), EES addresses clinical priorities and improves clinical outcomes by providing a safe, supportive environment in which practitioners master skills, practice protocols, learn system-based practices, apply critical decision making, and improve communication and interpersonal skills.

- Serves as managing partner for the Federal Healthcare Training Partnership (FHTP) consisting of agencies (including Department of Defense) that collaborate and share continuing medical education training programs among partner organizations with a clinical, public health training mission. EES shares at no cost continuing medical education/continuing education in the health professions training programs on the VHA TrainingFinder Real-time Affiliated Integrated Network (TRAIN). A service of Public Health Foundation, TRAIN operates through collaborative partnerships with state and federal agencies, local and national organizations, and educational institutions.

National Center for Organization Development

Overview

National Center for Organization Development (NCOD/10A2C), headquartered in Cincinnati, OH, supports efforts to improve the overall organizational health of VA, supporting the development and sustainment of healthy organizations where employees want to work and Veterans want to receive services.

Functions and Activities

- Administers the annual All Employee Survey. Analyzes the responses, presents results within 6 weeks of survey closing, and assists with action planning across VA (#1 diagnostic tool for employee engagement).
- Provides consultation to leaders at all levels of VA to improve organizational health, including consultation on change management, resilience, virtual teams, executive team building, engagement, psychological safety, and other factors relevant to developing leaders and engaging employees.
- Provides onsite consultations to various organizational units, including intensive workplace interventions at all levels of the organization.
- Supports the VA Civility, Respect and Engagement in the Workforce (CREW) initiative focused on raising awareness of civility and respect among coworkers, and increasing their understanding of the relationship between civility, patient care, and business outcomes.
- Offers executive coaching expertise to current and developing leaders within the organization.
- Implements the VA Team Model; administers and interprets Executive Team Assessment and Leadership Team Assessment Instrument to increase leadership effectiveness in conjunction with executive coaching and/or executive team consultation.
- Develops and applies multiple Web-based assessment tools: Executive 360-degree, 360-degree, 180-degree, and Servant Leader 360-degree assessments; resilience assessment; and change management assessments.
- Conducts management studies resulting in data-driven, qualitative and quantitative research, and publications.

Office of Academic Affiliations

Overview

The Office of Academic Affiliations (OAA/10A2D) is headquartered at VACO and has multiple field-based staff that oversee VA's statutory mission to train health professionals. OAA provides leadership, advice, and subject matter expertise across the full range of VHA's health professions education programs, including trainee education policy, training budget development and execution, and academic affiliation relationships.

Functions and Activities

- Ensures VHA's trainee educational programs are relevant to both VHA and national clinical workforce needs and holds responsibility for the development, analysis, oversight and evaluation of all policies, guidelines and programs relating to health professional trainees and academic affiliation matters.
- Develops strategic and operational alliances with key stakeholders, including VA medical facilities, other VHA program offices, VA Staff Offices, academic affiliates, accreditation and credentialing bodies, other Federal agencies, and professional societies.
- Fosters excellence and innovation in trainee education through transformative learning projects.
- Provides guidance, mentoring, and development opportunities to field education leaders, and collaborates with other Workforce Services program offices on workforce development and succession planning.

Healthcare Leadership Talent Institute

Overview

Healthcare Leadership Talent Institute (HLTI/10A2E) is a new office charged with developing an integrated talent management system from the local to the national level that is characterized by informed, structured, ongoing and deliberate processes to identify, develop and leverage the leadership talents inherent in each healthcare professional, resulting in a cadre of ready willing and capable leaders to step into VHA's most demanding roles.

Functions and Activities

- Utilizes an integrated system to identify, develop and manage VHA talent to meet the need for high performing transformational healthcare leaders aligned with the VHA mission and strategic direction.
- Promotes and manages healthcare leadership programs and developmental opportunities that maximize the acquisition of healthcare leadership competencies through growth activities that are 70 percent experiential (e.g. details, assignments, committees), 20 percent exposure (e.g. coaching, mentoring, shadowing) and 10 percent education and training.
- Coordinates responsibilities among VHA and VA organizations for key elements of healthcare leadership development to minimize gaps and overlaps and to support clear processes for

identifying needs and designing, implementing and evaluation healthcare leader development efforts.

- Oversees VHA succession and workforce planning; identifies and monitors talent needs and trends within the organization, and links succession planning and business strategies, presenting VHA with the opportunity to reach long-term goals and achieve human capital objectives.
- Institutes policies, procedures, practices and metrics necessary to support and evaluate talent management across VHA.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV

5 U.S.C. 5

38 U.S.C.

P.L. 79-293

P.L. 89-785

P.L. 92-541

P.L. 93-82

P.L. 96-151

P.L. 96-330

P.L. 98-160

P.L. 100-322

P.L. 102-40

P.L. 102-405

P.L. 106-117

P.L. 106-419

P.L. 108-170

Office of Finance

Overview

The Office of Finance is the principal financial advisor to the Under Secretary for Health. The office has an overarching responsibility for VHA budget development and allocation; it monitors the execution of funds to networks, guides, and oversees financial management and accounting operations, and maintains the Managerial Cost Accounting System for VA. The Office of Finance is composed of four major organizational elements: Financial Management and Accounting Systems, Resource Management, Financial Assistance, and Managerial Cost Accounting, through which functions and tasks are carried out.

Financial Management and Accounting Systems Office

Overview

The Financial Management and Accounting Systems Office (10A3A) (located in Washington, DC and Austin, Texas) establishes and implements policies and procedures governing financial management and accounting, internal controls management, and analysis of financial information and activities in support of financial statement reporting. This office is subdivided into two sections; Financial Management and Accounting Policy, and Financial Analysis and Oversight.

Functions and Activities

- Develops VHA policies and oversight activities related to payroll, cash/debt management, accounting, and financial policy.
- Provides guidance and direction to ensure compliance with OMB, the GAO, Treasury, and VA requirements; publishes policy and procedures; and provides accounting and financial management guidance.
- Establishes and maintains operational internal controls consistent with official guidelines.
- Analyzes financial information and activities at the national and facility level in support of financial statement reporting.
- Develops and implements VHA financial internal review programs, reviews internal and external audits and reviews, and develops corrective actions to avoid or remedy material weaknesses.

Resource Management Office

Overview

The Resource Management Office (10A3B) (located in Washington, DC and Braintree, Massachusetts) provides VHA budget formulation, allocation, execution and analysis, and health care workload and cost analyses.

Functions and Activities

- Develops, formulates, submits and defends VHA portion of the annual President's budget submission to Congress.
- Provides the allocation of VHA appropriation funds using the Veterans Equitable Resource Allocation (VERA) model and the Specific Purpose budget processes, issues Transfers of Disbursing Authority (TDAs) to VHA stations and program offices.
- Monitors execution of VHA funds and provides periodic formal budget analyses, such as the Quarterly Status Report to Congress, the Monthly Performance Review for the Deputy Secretary of VA, and the monthly execution and enrollment report for the Office of Management and Budget (OMB). Manages annual budget execution for the VHA Headquarters (Station 101).
- Formulates patient cost and workload data that is used in financial reporting for budget and resource allocation. Provides health care workload and cost analyses and end-user reports on VERA, financial management and related topics. Maintains reports and products on the ARC website and provides VERA education and training at all levels of VHA.

Financial Assistance Office

Overview

The Financial Assistance Office (10A3C) (located in Washington, DC and Austin, Texas) reviews, audits and oversees special program fiscal performance, compliance with fiscal policy and Federal accounting rules, and clarifies applied finance guidelines.

Functions and Activities

- Provides reporting on the Improper Payment Elimination and Recovery ACT (IPERA) for the Agency Financial Report (AFR).
- Provides financial assistance to the Research Nonprofit Corporation Program Office.
- Verifies and ensures accounting and financial policy compliance and coordinates fiscal quality assurance reviews.
- Assists VHA program managers in meeting their responsibilities to improve performance (efficiency, accountability, and economy) of operations and resource management.

Managerial Cost Accounting Office

Overview

The Managerial Cost Accounting Office (MCAO/10A3D), located in Washington, D.C. and Bedford, Massachusetts, maintains and provides information services from the VA's Managerial Cost Accounting system, the Decision Support System (DSS), in full compliance with public laws. DSS is an activity-based cost system that provides the full cost of VA products and services through the processing of financial and workload feeds from several VA systems. MCAO provides detailed cost information reports for dissemination to Congress, Government Accounting Office (GAO), OMB, and other entities external to VA, and provides data and conducts detailed cost analyses in support of VA organizations that evaluate staff productivity, business efficiency and resource allocation.

Functions and Activities

- Responsible for the complete, accurate and timely processing of all VA Cost Data.
- Ensures that MCA business practices and data processing have the highest level of standardization and transparency.
- Provides detailed subject matter expertise to the entire VA financial community, as well as VHA clinicians at all levels.
- Provides web master services to the DSS Reports Web Site, to include the development and maintenance of technically sophisticated (and content rich) web reports and data cubes.
- Delivers an effective-user education and training program to, both headquarters and field staff at all levels.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV

OMB Circular A-123: Management's Responsibility for Internal Control

Federal Acquisition Regulation (FAR)

44 U.S.C. 3541

P.L. 101-576

P.L. 111-81

P.L. 111-201

EO 13520

Office of Strategic Integration

Overview

The Office of Strategic Integration (OSI) facilitates the successful implementation of the VHA Strategic Framework and supports the development of a systematic approach to the design, evaluation, and diffusion of new capabilities. OSI collaborates with stakeholders to define and achieve common goals while optimizing standardized business processes to ensure coordination, integration, and effective execution of the VHA Strategic Plan.

Functions and Activities

- Provides strategic direction, tactical planning, oversight, and integration of projects and programs that are developed in support of the VHA strategic intent, including VA and VHA strategic planning artifacts such as the Strategic Plan, the Blueprint for Excellence, and other approved planning artifacts.
- Ensures that business and clinical practices are designed to support strategy, and aligns efforts to ensure organizational resiliency and readiness for change.
- Fosters benchmarking, innovation, integration, and discovery to advance VHA's strategic intent and identify future opportunities.
- Provides consultation, project management expertise, repeatable processes, and reusable tools designed to facilitate successful execution of strategy.
- Serves as principal liaison to VA's OPP and the enterprise Program Management Office on matters relating to VHA Transformation Major Initiatives.
- Serves as principal advisor and liaison to VHA's executive leadership on matters relating to VHA Transformation efforts through the Principal Deputy Under Secretary for Health.
- Integrates efforts with stakeholders within VA, other Federal partners, and community organizations to advance VHA's strategic plan.
- Functions as the VHA Senior Executive Team's Program Management Office, coordinating and facilitating multiple enterprise initiatives (including, but not limited to: Access, Diffusion of Best Practices, Leaders Developing Leaders, Implementation of the Veterans Access, Choice and Accountability Act (VACAA), VA Pulse, Implementation of Independent Assessments/Commission on Care Recommendations, Care in the Community, Design Thinking/Human Centered Design, Programming and Requirements Gathering in Service of "Managing for Results," and the development of high level acquisitions) under the auspices of VHA senior officials.

Authorities

VHA Executive Decision Memo: "Mission Change: Office of Healthcare Transformation," signed April 10, 2013.

Office of the Deputy Under Secretary for Health for Policy and Services

Overview

The Office of the Deputy Under Secretary for Health for Policy and Services (DUSHPS) is dedicated to ensuring excellence in the full continuum of health care policy, information management, research, ethics, and public health-related services. It provides oversight of DUSHPS programs and aligns them with the strategic objectives and agency priority goals (APGs) articulated by the Department, as well as VHA strategic goals.

Through the Office of Community Engagement, DUSHPS facilitates and strengthens VHA collaborations within communities and with public and private organizations to improve the health and wellness of Veterans, their family members, and caregivers.

Functions and Activities

- Advises the USH, PDUSH, and other principal officials on all matters pertaining to the health policy and programs and develops and presents policies, plans, and programs for appropriate decision making.
- Catalyzes innovation and promotes diffusion of best practices and technologies throughout VHA by using innovative approaches and technologies and collaborating with partners within and outside VHA.
- Ensures effective coordination of policies and programs within VHA and communicates and advocates VA policies, plans, and programs to external audiences on all matters pertaining to VA health care system. Also serves on internal and external committees and represents VHA interests.
- Oversees the office strategic planning process, identification of best practices and evaluation mechanisms, including process and outcomes measures.
- Collaborates with Operations and Quality, Safety and Value (QSV) arms of the organization to serve as a bridge for safe and effective delivery of health care services.
- Guides and oversees the responsible ADUSHs and Chief Officers in developing, implementing, executing, and supervising where appropriate, the execution of VA policy, plans, programs, budgets, and activities.
- Oversees the execution of Policy and Services acquisitions, financial management, travel, human resources management, and space and information management strategic plans and the productivity and management of Policy and Services programs.
- Promotes partnerships between VHA program offices, field offices, and non-VA organizations by providing best practices, tools, and training on how to develop and sustain effective partnerships.
- Serves as a national resource and point of contact within VHA, the Department, and outside organizations seeking guidance on how to create or manage effective collaborations. Develops VHA guidance and tools pertaining to responsible and productive partnerships.

Authorities

38 U.S.C. 73

Office of the Assistant Deputy Under Secretary for Health for Policy and Planning**Overview**

The VHA Office of Policy and Planning (OPP/10P1) advances Veteran health care through mission-critical planning, forecasting, information and policy analysis.

*Policy Analysis and Forecasting (10P1A)***Overview**

Policy Analysis and Forecasting (10P1A) facilitates the delivery of high-quality health care by providing analytics to support policy decisions and advance system effectiveness.

Functions and Activities

- Participates in the development of health care policy in support of VHA strategic goals.
- Advances development/utilization of the VA Enrollee Health Care Projection Model (EHCPM) to forecast Veteran enrollment, demand and resource requirements for VA health care services, and to support the VA medical care budget process, and strategic and capital planning activities.
- Provides leading edge, geospatial analysis and tools that are used across VA to optimize health care access; enables decision-makers to “visualize choice”.
- Conducts special studies and analyses that support VHA strategic planning, direction, and collaboration.
- Coordinates the acquisition and distribution of Medicare and Medicaid data throughout VHA, and conducts analyses of dual eligible beneficiaries using VHA and Centers for Medicaid Services (CMS) data.

Overview

Strategic Planning and Analysis (10P1B) advances access to high-quality health care services for Veterans and their families through effective and integrated system wide strategic thinking and planning.

Functions and Activities

- Conducts complex quantitative and/or qualitative analysis to assess planning, policy and health care trends.
- Analyzes and synthesizes information in support of national policies, decision making and organizational improvement.
- Administers the annual national VA Survey of Veteran Enrollees’ Health and Use of Health Care, which gathers essential information on drivers of Veteran utilization of health services in support of the annual VHA projections of enrollment, utilization and expenditures.
- Leads, supports, and coordinates VHA strategic planning initiatives.

- Coordinates VHA alignment to VA strategic plan and reporting requirements.
- Collaborates within and outside of VA, including with other Federal agencies, to improve analysis, planning and cooperation for high quality, effective, integrated delivery of benefits and services for Veterans, Service members, retirees, and their families.

Office of Rural Health

Overview

Rural Health (10P1R) works to increase access to quality health care services for Veterans residing in rural and highly rural areas of the country.

Functions and Activities

- Meets the objectives of P.L. 109-461 and P.L. 112-154 to expand and enhance the delivery of health care to rural Veterans, and ensures integration with overall planning efforts.
- Conducts studies and analyses on rural Veteran health care needs and health outcome disparities, and promulgates best practices in rural health care delivery.
- Works to improve the health care infrastructure where rural Veterans reside.
- Works to improve the health and well-being of rural Veterans.
- Works to inform health care policy that impacts rural Veterans and rural health care delivery.
- Obligates and oversees Office of Rural Health funding used to support VA rural health initiatives.

Authorities

38 U.S.C. 73

P.L. 109-461 § 212 (7307-7308)

P.L. 112-154

Office of the Assistant Deputy Under Secretary for Health for Informatics and Information Governance

Overview

The Office of Informatics and Information Governance/10P2 (OIIG) supports VA's health care system, clinicians, and program office staff by: ensuring that applications and data systems are deployed in a manner that meets the requirements of VHA users; enhancing health data exchanges with federal and private partners; and providing policy and guidance to Informatics, Freedom of Information Act (FOIA), Library, Privacy, Health Information Management and Records Management personnel nationwide. OIIG optimizes VA's world-class electronic health record (EHR) to promote evidence based decision-making and patient-centered care.

*Health Informatics (HI)/10P2A***Overview**

Health Informatics (HI)/10P2A is the focal point for advancing VA's Electronic Health Record (EHR) and information systems. HI serves as the primary advocate for field clinicians regarding Health Information Technology (HIT) and provides program support to HIT solutions such as the Virtual Lifetime Electronic Record (VLER) Health Program, VistA Evolution (VE), and the enterprise Health Management Platform (eHMP).

Functions and Activities

- Provides leadership, direction, facilitation, and coordination for clinical informatics activities throughout VHA and continue as industry leaders in the use of health informatics and HIT.
- Provides clinical informatics subject matter expertise, program management, and leadership in the collaborative design, development, and deployment of innovative and technologically robust next-generation clinical and health applications, including VE.
- Manages information exchange with private and federal partners, including VLER Health Exchange (VA and non-VA providers request and share Veterans' health information) and VLER Health Direct (allows VA providers to send and/or receive specific information to and from non-VA providers via secure email).
- Manages and oversees interoperability solutions which establish health information sharing and exchange with DoD and other government partners, including Federal Health Information Exchange (FHIE), Bi-directional Health Information Exchange (BHIE), and Clinical Health Data Repository (CHDR).
- Aligns clinical and business operations associated with positive patient identification scanning technology solutions (i.e., Bar Code) for automated data capture, including traceability of pharmaceuticals, medical devices, and medical implants.
- Optimizes the user experience with VHA health information systems to facilitate care delivery and patient wellness.
- Develops training resources available to all VA Central Office and field staff, with over 300 training sessions available on OIIG's virtual learning platform <http://www.myvehucampus.com>.
- Optimizes the use of best practices for improving patient safety and the user experience with VHA health information systems to facilitate care delivery and patient wellness.

*Health Information Governance***Overview**

The Office of Informatics and Information Governance/10P2 (OIIG) supports VA's health care system, clinicians, and program office staff by: ensuring that applications and data systems are deployed in a manner that meets the requirements of VHA users; enhancing health data exchanges with federal and private partners; and providing policy and guidance to Informatics, Freedom of Information Act (FOIA), Library, Privacy, Health Information Management and Records Management personnel nationwide.

OIG optimizes VA's world-class electronic health record (EHR) to promote evidence based decision-making and patient-centered care.

Functions and Activities

- Provides oversight and guidance to field facilities on coding, documentation, and records management and trains clinicians, health information management staff, and records management staff throughout the VA health care system.
- Serves Veterans and VA employees by ensuring health care security requirements are maintained through coordinated standardized processes, ongoing compliance assurance, and integrated during the Software Development Lifecycle.
- Provides subject matter expertise and oversight of International Classification of Diseases version 10 (ICD-10) Coding System implementation including responsibility for the ICD-10 Program Office.
- Serves as VHA's FOIA Officer and VHA's Privacy Officer and as VHA HIPAA Security Subject Matter Experts (SME).

Strategic Investment Management

Overview

SIM/10P2E facilitates sound decision-making for the development, acquisition, and maintenance of health-focused information technology investments by providing leadership with a comprehensive understanding of needed VHA business capabilities including business requirements, processes, information needs, IT strategy and priorities, and investment analysis.

Functions and Activities

- Serves as the champion for VHA IT needs within VA's Planning, Programming, Budgeting, and Execution (PPBE) process, including managing VHA's requirements repository.
- Informs decision making for prioritization of IT funding/investments and business-driven sequencing of future health information functionality.
- Organizes current and future business knowledge; gathers, documents, analyzes and evaluates clinical and business requirements, business processes, and business information needs for IT development.
- Serves as the integration agent of VHA business information to enable translation of VHA strategy and business/mission into structured long-term IT plans.
- Provides custodial management and serves as information stewards of VHA business information to support business owners.
- Collaborates with other VHA and VA organizations to provide timely, relevant information and data services that support improvements in provision of Veterans' health IT systems and services.
- Supports VHA governance and decision-making on IT investments.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV

The Privacy Act of 1974

The Paperwork Reduction Act (PRA) of 1980

The Health Insurance Portability and Accountability Act (HIPAA) of 1996

The Government Paperwork Elimination Act (GPEA) of 1998

The Electronic Government Act of 2002

The Federal Information Security Management Act (FISMA) of 2002

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009

The Patient Protection and Affordable Care Act (PPACA) of 2009

Freedom of Information Act (FOIA)

The Clinger-Cohen Act of 1996 (Information Technology Management Reform Act)

38 U.S.C. 5701

Office of the Assistant Deputy Under Secretary for Health for Patient Care Services**Overview**

Patient Care Services (PCS/10P4) provides leadership for policy and program development to enable VA to provide the best possible healthcare for our Nations' Veterans. PCS is dedicated to ensuring the full continuum of health care, which comprises health promotion, disease prevention, diagnostics, therapeutic and rehabilitative care, recovery and palliative care. Utilizing innovative approaches and technologies through interdisciplinary collaboration both within and outside of VHA, PCS policy and program development supports dignity and respectful care for Veterans. Recently, the Office of Public Health realigned with PCS expanding the mission to include post-deployment health, population health, employee health and wellness, as well as a few clinical public health programs.

Functions and Activities

- PCS provides leadership and policy to enable VA to provide the best possible health care for our Nations' Veterans.
- Provides leadership and advisory services, which are oriented toward providing general management solutions to achieve optimum overall program balance in relation to the VA and VHA mission.
- Provides guidance to VISNs and promulgates incorporation of health care guidelines, policies and strategies, reviews program adequacy, effectiveness, and quality.

*Deputy Chief Patient Care Services Office***Overview**

The Deputy Chief Patient Care Services Office (DCPCSO/10P4A) supports PCS by providing the leadership and infrastructure to support strategic planning activities and operationalizing performance goals and metrics that support the MyVA transformation and align with the VA/VHA Strategic Plan, Under Secretary for Health top five priorities and the Blueprint for Excellence. The DCPCSO provides and supports clinical subject matter expertise on a range of healthcare issues that influence policy development and care delivery. The DCPCSO oversees functions are policy, advisory, and clinical support services in nature.

Functions and Activities

- Advises on developing a comprehensive PCS strategic vision including organizational objectives and execution approaches, alignment, functional assignments, strategic development of patient care, performance measurement, leadership development succession planning.
- Supports development of clinical guidelines, protocols or "best practices" to be used in the delivery of clinical care services, and participates in Department-wide activities involving VA Quadrennial Strategic Planning Process, Gap Analysis, and Environmental Scan and Execution Team.
- Provides monitoring and oversight on status of PCS Policies (handbooks, directives, manuals), identifies policies that need to be rescinded or recertified, and works with 10B4 to expedite necessary policy actions.
- Identifies conflicts that exist with current policy, prioritizes policies for resolution, and develops action plan to resolve current conflicts.
- Responds to Departmental, administration, congressional, OIG, GAO, VSO, and media inquiries.

Associate Chief Patient Care Services Office

Overview

The Associate Chief Patient Care Services Office (ACPCSO/10P4B) leads an effective administrative activity to support PCS leadership by providing oversight and daily operational management, monitoring, and coordinating and tracking executive correspondence and taskers, communications, human resources, IT, training, and financial management. The ACPCSO oversees and coordinates activities related to data use agreements for all PCS offices, and manages and monitors all critical PCS program office functions.

Functions and Activities

- Assists PCS with oversight and coordination of decentralized staff and other field operations, including development of annual business plans and liaison with management at host VA medical centers.
- Provides oversight of budget development and execution for over \$5.4 billion in Specific Purpose accounts.
- Responds to Departmental, administration, congressional, OIG, GAO, VSO, and media inquiries and provides leadership in executive correspondence development and tracking, Privacy Act, Clinical Restructuring, Data Use Agreements, congressional reports, correspondence and written policy documents.
- Oversees communications to promote and advocate for excellence in healthcare for Veterans with Grand Rounds, Annual Reports, Newsletters, Town Hall meetings, Web and SharePoint sites, Idea House blog, VA Pulse, and increasing use of social media sites.
- Coordinates and oversees the successful development of legislative initiatives, regulations, and policies to accomplish the goals of PCS.

- Provides oversight in human capital management including All Employee Survey, PCS Annual Award Program, position management performance management, incentives, workforce development and succession planning to ensure optimal use of resources and highest quality and level of morale of workforce.

Care Management and Social Work Services

Overview

Care Management and Social Work Services (CM&SWS/10P4C) supports and advances the mission of VHA by providing comprehensive and specialized psychosocial support services to Service members, Veterans, their families, and caregivers. These services include transition assistance, assessment, crisis intervention, high-risk screening, discharge planning, case management, advocacy, education, supportive counseling, psychotherapy, resource referrals, and resource acquisition. Care Management and Social Work Services are delivered by field based staff located in every VA Medical Center. 10P4C develops policy and oversight of the six national programs that are organizationally aligned to the service. In addition, one of the fundamental roles of 10P4C is providing support to field based staff in the delivery of care.

Functions and Activities

- Provides caregiver support services nationwide to ensure Veterans and their family caregivers have access to services and programming to support them in their role as family caregivers. Also provides support services directly to family caregivers ensuring that Veterans who can no longer care for themselves can remain in their homes with adequate support.
- Provides assistance to families of Veterans, Active Duty Service members, and their families through the Family Hospitality Program. Resources include the VA Fisher House Program, which provides temporary accommodations for the families and Caregivers of Veterans and Service members who are receiving medical care at VA medical facilities nationwide.
- Provides temporary lodging for Veterans receiving outpatient VA medical care or Compensation and Pension examinations. Veterans may be accompanied by family members or Caregivers to provide additional support during the course of treatment.
- Provides direct transition assistance at military treatment facilities to post 9/11 era Service members and Veterans, including those who served in support of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) as they transition from DoD to VA.
- Provides comprehensive and specialized psychosocial support and transition assistance to Veterans during reintegration into their home communities and throughout the continuum of their VA care.
- Serves as Lead Coordinator by providing case management for ill and injured Service members and Veterans returning from service who have a need for complex care coordination.
- Provides policy guidance and has the lead on developing and implementing the Intimate Partner (IPV) Assistance Program for VA health care.

- Provides policy development and guidance on the provision of social work services at VA health care facilities, leadership development, and oversight for the professional practice of social work.
- Maximizes health and well-being through the use of psychosocial interventions for Veterans, families, and caregivers.

Diagnostic Services

Overview

Diagnostic Services (10P4D) provides subject matter experts in the fields of pathology, laboratory medicine, radiology, and nuclear medicine. The services function in the settings of ambulatory care, acute care, mental health, geriatric and rehabilitative care.

Functions and Activities

- P&LMS provides guidance to the senior leadership and field employees in the VA, VHA, and the VA laboratory community to ensure timely, cost-effective, and high quality anatomic and clinical pathology services are provided for VA patients and caregivers.
- Radiology advises on matters of policy and makes recommendations on courses of action to all levels of VHA in order to ensure and facilitate the provision of high quality diagnostic imaging care that is safe, timely, and cost-effective.
- Nuclear medicine provides counsel and expertise to stakeholders, including VACO, VISNs, and VAMCs, by disseminating trends from type of studies performed, monitoring quality benchmarks, and new methods in the delivery of nuclear medicine Veteran care.
- The National Teleradiology Program provides 24/7 diagnostic radiology services to VHA facilities located in all VISNs, rendering final diagnostic interpretations on a wide variety of modalities including computerized tomography scans CTs, X-rays, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine imaging studies.

Specialty Care Services

Overview

Specialty Care Services (SCS/10P4D)) is a large service, encompassing 16 distinct medical specialties, chaplaincy, nutrition and food services, as well as neurology centers of excellence and a SCS center for innovation. SCS ensures the best overall clinical, preventive, spiritual, religious, and nutritional care is available to Veterans. Both policy and program development utilize innovative approaches, technologies and interdisciplinary collaboration both within and outside of VHA promoting-dignity and respect for our Veterans.

SCS provides national leadership on programs and initiatives, policy matters and issues relating to care delivery, assessment of services, and outcome analysis for twenty (20) key specialty care areas.

The Chief Consultant, in collaboration with Field-based National Program Directors, serves as the principal advisor to the Assistant Deputy Under Secretary for Health for Patient Care Services, Deputy

Under Secretary for Health for Policy and Services, Principal Deputy Under Secretary for Health and Under Secretary for Health.

Functions and Activities

- Allergy offers state of the art care for Veterans with allergic and immunologic disorders. The VHA-DOD Allergen Extract Program provides state-of-the-art centralized immunotherapy and diagnostic testing material for Veterans with seasonal or perennial inhalant allergies, food allergies and insect venom sensitivities.
- Provides guidance and consultation on matters regarding the practice of Anesthesia, including pain management during surgical, obstetrical, therapeutic and diagnostic procedures; monitoring and restoring homeostasis during the perioperative period; and the management of cardiac and pulmonary resuscitation. Anesthesia collaborates with Surgery and Pain Medicine.
- Provides information, guidance, and oversight to Cardiology initiatives ensuring the delivery of quality cardiac care. The Cardiac Implant Surveillance System remotely monitors implant performance. The National Implantable Device Registry follows Veterans with cardiac implants, and tracks recalls and device-related problems.
- Chaplain Services offers religious, spiritual, and pastoral care to ensure Veterans' right to free exercise of religion and integration of spiritual and pastoral care is fully into the care and treatment program of each health care facility.
- Develops and implements Emergency Medicine national triage protocol system and works in collaboration with all specialties, including Neurology and Cardiology for stroke and heart attack management.
- Endocrinology/Diabetes develops and implements guidelines for prevention, treatment and tracking of care and assessment of medical outcomes. The Diabetes Program collaborates with the National Prevention Center, Food and Nutrition Services, Podiatry, Eye Care and the Office of Research and Development.
- Oversight and management of the VA-Vision Registry, a VA/DoD collaboration on ocular injury and treatment is provided by Eye Care (Ophthalmology & Optometry). The Vision Center of Excellence advocates for programs and initiatives across the VA and DoD for prevention, diagnosis, treatment, rehabilitation and research of eye injuries and diseases, including visual dysfunctions related to Traumatic Brain Injury. The national Tele-Retinal Imaging Screening Program with the VHA Telehealth Services Improves access.
- Guidance, advice, and oversight on all matters related to diseases of the gastrointestinal tract is the domain of Gastroenterology including the demand for services (e.g. colorectal cancer screening and surveillance and hepatitis C and end-stage liver disease management) and a national endoscopy reporting process that facilitates quality assurance. Collaborates with Infectious Disease, Anesthesia, National Center for Prevention and Clinical Public Health Group.
- Genomic Medicine facilitates the application of genetic technologies and encourages translational genomics research to improve the health care of Veterans. Coordinates genetic

counseling functions, establishes strategic guidance regarding the phased integration of clinical genomic testing, and organizes bold education initiatives.

- Infectious Disease develops national policy in clinical practice, prevention of healthcare-associated infection and multi-drug resistant organism infections, antimicrobial stewardship, infection prevention/control, and bio-surveillance/ preparedness. Collaborates with numerous VA and VHA Offices, Programs and Services; Federal Agency partners; professional groups, and numerous non-Federal entities.
- Nephrology oversees the diagnosis and treatment of kidney diseases. Develops strategic plan addressing potential to increase hospital-based dialysis capacity and potential at-home dialysis options.
- Neurology oversees research, clinical care, and education for neurological disorders through two Multiple Sclerosis Centers of Excellence; six Parkinson's Disease Research, Education, and Clinical Centers; and four regional Epilepsy Centers of Excellence. Neurology collaborates with Emergency Medicine and Rehabilitative Services on the treatment of stroke, traumatic brain injury and amyotrophic lateral sclerosis.
- Nutrition and Food Services (NFS) develops and provides comprehensive nutritional services for our Veterans participating in Telehealth, the Patient-Aligned Care Team, Culture Transformation, and social media communications. NFS is transforming advanced nutrition practices and health teaching programs to improve health outcomes for Veterans and their families.
- Oncology coordinates the Cancer Registry System/Central Cancer Registry and provides policy, guidance, and oversight to the implementation of the National Cancer Strategy addressing prevention, education, screening, early detection, diagnosis, treatment, rehabilitation and research.
- Pain Medicine educates Veterans/families, clinical team members including integration of non-pharmacological modalities, evidence based medication prescribing, use of pain procedures, safe opioid use and expansion of virtual care. Establishment of metrics to monitor pain care and outcomes at both the individual level and the population level.
- Medical and surgical foot and ankle care is the charge of Podiatry including the amputation/ulcer database and High-Risk for Amputation ProClarity Cubes. Podiatry works closely with Endocrinology/Diabetes developing and implementing initiatives to prevent and treat complications of diabetes.
- Pulmonary/Critical Care provides guidance, advice, and oversight to ambulatory and hospital-based programs, including intensive care units regarding respiratory disorders including chronic obstructive pulmonary disease and sleep disorders. Pulmonary/Critical Care closely collaborates with Cardiology, Pharmacy Benefits, and Infectious Diseases.
- The Specialty Care Centers of Innovation improve access to and the efficiency of specialty care by reducing delays and employing Specialty Care Education, Technology and Innovation.

*Primary Care Services***Overview**

Primary Care Services (10P4F) oversees program and policy development for primary care in VHA. VHA Primary Care honors America's Veterans by providing quality and accessible primary care to all Veterans. It promotes patient-centered care that focuses on an integrated, comprehensive approach to health care. Primary Care Services plays a significant role in the implementation of Patient Aligned Care Teams (PACTs) nationwide, which promotes team based, patient-centered care that focuses on a personalized, integrated, comprehensive and coordinated approach to health care. Other national programs and services provided under Primary Care Services include: Primary Care-Mental Health Integration (PCMHI) and Post-Deployment Integrated Care (PDIC).

Functions and Activities

- Advises the Under Secretary for Health, Deputy Under Secretary for Health for Policy and Services, Assistant Deputy Under Secretary for Health for Patient Care Services, VHA Program Offices, other governmental agencies, and field on issues related to Primary Care.
- Identifies strong PACT clinical practices worthy of further evaluation or development, and communicates this information to VISN and facility leaders. Participates in the development and implementation of internal certification processes that identify and recognize high performing PACTs. Identifies and promotes education regarding relevant PACT topics to primary care staff.
- Promotes the alignment of PACT processes and function with space design principles and standards to promote high performing teams, in collaboration with the Assistant Deputy Under Secretary for Health for Administrative Operations (10NA). Oversees the development of enhancements to the Primary Care Almanac, a web-based population management tool for PACT that provides performance improvement capabilities to PACT staff.
- Identifies and promotes alternate access to care, including group visits, telephone visits, disease management clinics using clinical pharmacy specialists, secure messaging via e-mail, and the provision of care remotely via Telehealth.
- Works with Specialty Care to implement the chronic care model for healthcare emphasizing a comprehensive and coordinated approach to care. Partners with Specialty Care and other program offices to promote safe and effective patient care including chronic pain management and opioid use including the Joint DoD/VA Pain Education Project, the Opioid Safety Initiative.
- Participates in the identification of metrics suitable for national display (on a dashboard called the "Compass") that identify national benchmarks to encourage performance improvement and enhance standardization of care nationally.
- Promotes the use of applied research, such as that performed by the PACT Demonstration Labs, Quality Enhancement Research Initiative, or VA Health Services Research and Development to inform the effectiveness of the PACT model. Facilitates pilots and other programmatic efforts to incorporate research results into the health care delivery system such as the PACT Intensive Management.

Other national programs and services provided under Primary Care Services include:.

- Primary Care-Mental Health Integration (PCMHI) which promotes full incorporation of mental health staff into the PACT to allow provision of depression, anxiety, PTSD, and substance abuse services without the need of a separate Mental Health Consult to a new health provider located outside of the PACT clinic area.
- Post-Deployment Integrated Care (PDIC) features the development of specialized PACTs with expertise and training in syndromes common to returning combat Veterans, such as depression, substance abuse, PTSD, chronic pain, sleep disorders, and anxiety. These teams are typically well staffed with social workers, mental health and behavioral specialists allowing comprehensive care within the PACT itself.

The Geriatrics and Extended Care Service

Overview

The mission of Geriatrics and Extended Care (GEC/10P4G) is to empower Veterans and the Nation to rise above the challenges of aging, disability or serious illness. GEC Service provides leadership, planning, and policy in support of the GEC mission to honor Veterans' preferences for health, independence, and well-being in the face of aging, disability, or illness by advancing expertise, programs, and partnerships. GEC programs are built upon expertise in three specific areas: Geriatrics, Palliative Care, and Long-Term Services and Supports (LTSS). Geriatrics is a healthcare specialty that focuses on the care of older adults and age-related conditions. Palliative care is a specialty that focuses on optimizing quality of life for patients with serious illness and includes expertise in hospice care during the last six months of life and symptom management throughout the course of chronic or serious illness. LTSS offers programs and services required by Veterans needing assistance with activities of daily living.

Functions and Activities

- Advises VA and VHA leaders, other governmental agencies, and field staff on policy and plans for Geriatrics, Palliative Care, and Long Term Services and Supports (LTSS). Optimizes Veteran health by ensuring access to Geriatrics, Palliative Care, and LTSS.
- Improves health, function, and well-being of Veterans; decreases preventable hospitalizations and nursing home admissions, and reduces total health care costs for Veterans.
- Through Facility Based LTSS, operates Community Living Centers (CLC), which are VA-owned and operated facilities that resemble "home" as much as possible, provide skilled level of facility-based care.
- Veterans may also receive nursing home level of care in Community Nursing Homes (CNH) or State Veterans Homes (SVH). Geriatric and Palliative Care Consultation services and Acute Care for Elder (ACE) Programs/Units are offered at many VA Medical Centers.
- Honors Veterans' preferences by balancing the delivery of LTSS in the home and community versus facility-based settings. Improves care quality, safety, value and the Veterans' experience by supporting optimal care coordination.
- Supports the development of workforce competencies required to care for Veterans facing the challenges of aging, disability, or serious illness. Facilitates research, education, innovations in

care, and program evaluations through twenty Geriatric Research, Education, and Clinical Centers (GRECCs), field centers, community partners and collaborators.

- Offers other GEC Services in Multiple Care Settings to include Advanced Care Planning, Care Coordination and Management, Comprehensive Geriatric Evaluation, Hospice, Innovative Community Based Alternatives to Nursing Home Care, Palliative Care, Shared Decision Making (SDM), and Telehealth.
- Geriatric Research, Education, and Clinical Centers (GRECC are centers of innovation at 20 different locations throughout the nation:
 - New England GRECC (sites at Boston and Bedford)—VISN 1.
 - Bronx GRECC—VISN 3.
 - Pittsburgh GRECC —VISN 4.
 - Baltimore GRECC—VISN 5.
 - Durham GRECC—VISN 6.
 - Birmingham/Atlanta GRECC—VISN 7.
 - Miami GRECC—VISN 8.
 - Gainesville GRECC—VISN 8.
 - Tennessee Valley GRECC (sites at Nashville and Murfreesboro)—VISN 9.
 - Cleveland GRECC—VISN 10.
 - Ann Arbor GRECC --VISN 11.
 - Madison GRECC – VISN 12.
 - Little Rock GRECC—VISN 16.
 - San Antonio GRECC –VISN 17.
 - Eastern Colorado GRECC—VISN 19.
 - Salt Lake City GRECC –VISN 19.
 - Puget Sound GRECC (sites at Seattle and American Lake)—VISN 20.
 - Palo Alto GRECC –VISN 21.
 - Greater Los Angeles GRECC—VISN 22.
 - Minneapolis GRECC—VISN 23.

Authorities

The Veterans' Health Care Eligibility Reform Act of 1996
 Veterans Millennium Health Care and Benefits Act
 38 CFR 17.36

38 CFR 17.38

*National Radiation Oncology Program***Overview**

Radiation Oncology (10P4H) manages the accreditation process for VHA radiation oncology services, which includes monitoring the creation and resolution of corrective action plans with the Network Office.

Functions and Activities

- Directly coordinates with the American College of Radiology Radiation Oncology Accreditation, arranging consultative surveys when necessary to monitor the VHA contract with the Imaging and Radiation Oncology Core (IROC), which provides external oversight for radiation delivery operations within VHA.
- Operates the VHA Radiation Oncology Field Advisory Committee (ROFAC), which is composed of VHA physicians and physicists who coordinate national program objectives with field operations.
- Provides subject matter expertise in the areas of the clinical practice of Radiation Oncology and medical physics for VHA. Coordinates inspection activities and error reporting with the Director, National Health Physics Program.
- Provides operation oversight as well as policy guidance for all of VHA radiation oncology operations, including monitoring clinic operations and infrastructure to ensure quality assured delivery of conventional and advanced radiation therapy; monitoring the clinical credentialing activities of the VHA ROS; overseeing VHA contracts for radiation oncology care; and monitoring the Radiation Incident Reporting and Analysis System (RIRAS).
- Coordinates with professional organizations to establish Memoranda of Understanding (MOU) and harmonize common operational standards for radiation delivery to improve Veteran care.
- Provides continuous communication with VHA ROS, Center and VISN leaders and Veterans and their families regarding VHA radiation oncology care operations. Establishes task forces as necessary to address specific clinical and operation issues within VHA radiation oncology.

*HIV, Hepatitis, and Public Health Pathogens***Overview**

HIV, Hepatitis, and Public Health Pathogens Programs (HHPHP/10P4I) supports and advances the mission of VHA by providing state-of-the-art clinical public health services to providers and Veterans in the areas of disease due to human immunodeficiency virus (HIV), viral hepatitis, and other public health pathogens (PHPs). In collaboration with other Patient Care Service and VHA offices, delivers practical tools that support best practices by providers; education and communication projects designed to inform and change provider and Veteran behavior; quality improvement initiatives that increase access to and quality of care; and as indicated, proposals for legislative and policy changes. Expertise includes clinical knowledge, particularly infectious diseases and associated co-morbid conditions; mental health services, particularly in relation to the impact of mental health comorbidities on chronic infections due

to public health pathogens; epidemiology; informatics; field-based communication, education and implementation; and project management.

Functions and Activities

- Identify and link to care Veterans with conditions due to HIV, viral hepatitis, and other PHPs, especially for underserved Veterans (e.g., homeless, women, rural OEF/OIF/OND Veterans).
- Improve care of these Veterans through evidence-based, system-wide quality improvement interventions.
- Support VHA providers by removing barriers to diagnosis and access to care for Veterans living with or at risk of infection by HIV, viral hepatitis, and other PHPs.
- Develop and maintain the resources (personnel, expertise, equipment, and funds) necessary to ensure that we fulfill our day-to-day duties and responsibilities.
- Use epidemiologic data, appropriate quantitative and qualitative metrics, and input from field providers and patients to identify structures and processes that affect access, quality and cost of care for Veterans with HIV, viral hepatitis, or other PHPs.

Physician Assistant Services

Overview

Physician Assistant Services oversees physician assistant (PA/10P4J) program and policy development in VHA. PA Services ensures that the utilization of PAs in VHA is optimized to provide quality and accessible care to Veterans. PAs provide medical care to Veterans across the spectrum of medicine and surgery. The occupation's flexibility in transitioning to different medical specialties is of significant strategic value when addressing shortages or changes in health care provider workforce needs.

Functions and Activities

- Advises the Under Secretary for Health, Deputy Under Secretary for Health for Policy and Services, Assistant Deputy Under Secretary for Health for Patient Care Services, VHA Program Offices, other governmental agencies, and field on issues related physician assistants.
- Conducts periodic review of VA qualification standards and clinical practice policy development for physician assistants and assists field facilities in policy implementation.
- Assists in workforce planning and the development and periodic review of a VHA Physician Assistant recruitment and retention plan.
- Identifies VHA PA workforce educational needs and collaborates with VA Employee Education Service (EES) to develop educational plans to meet needs.

Mental Health Services

Overview

Mental Health Services (MHS/10P4M) improves the quality and availability of a full continuum of mental health services, including prevention, outpatient and inpatient treatment, recovery, and rehabilitation

services to promote optimal mental health and quality of life, and reduce illness, death, disability and cost resulting from mental and substance use disorders (SUD) among Veterans.

Functions and Activities

- Promotes a Recovery Model throughout mental health care and specifically in the clinical areas of serious mental illness (SMI), posttraumatic stress disorder (PTSD), SUD, psychosocial rehabilitation, gender-sensitive mental health care, geriatric mental health, military sexual trauma, and residential rehabilitation (domiciliaries). Other key functional areas include informatics, education, research, and designated special programs, such as the National Center for PTSD, Mental Illness Education, Research and Clinical Centers (MIRECCs), advisory committees (SMI and PTSD), and Mental Health and SUD Centers of Excellence (CoE).
- The MIRECCs and other CoEs are field-based programs located across the country that promote effective prevention, treatment, rehabilitation and education policies, and services. The National Center for PTSD has 7 divisions across 5 locations, with the Executive Division at White River Junction, Vermont, and other divisions in Boston, West Haven, Palo Alto, and Honolulu.
- Works to eliminate the barriers that impede prevention, treatment, recovery, and rehabilitation services for Veterans with substance use disorders and mental illnesses.
- Responsible for development and coordination of smoking and tobacco-use cessation, and tobacco control policy and programs in the VA health care system. Additional functional areas include identification and development of clinical policies and programs to increase Veterans' access to evidence-based tobacco cessation care.
- Develops and promotes quality standards for service delivery. Develops, synthesizes, and disseminates information to improve prevention, treatment and rehabilitation services, and to improve the organization, financing and delivery of these services.
- Collaborates with other agencies (e.g. DoD, Indian Health Service, Substance Abuse and Mental Health Services Administration), National Cancer Institute to promote coordinated care for male and female Veterans and their families, and to enhance VA's preparedness to support the National Emergency Response Plan with mental health assets .
- Through Primary Care-Mental Health Integration (PCMHI) embeds mental health staff into the PACT to allow early identification and treatment for common uncomplicated mental disorders and health related behaviors within Primary Care. This approach to care reserves specialty mental health resources for individuals who need care for more complex to treatment resistant illness.
- Promotes the integration of mental health services in GEC programs including Home Based Primary Care, Community Living Center, and Palliative Care, facilitations access to mental health care for older Veterans.
- Trains VA mental health clinicians in evidence-based psychotherapies that treat PTSD, depression, substance use, serious mental illness, insomnia, chronic pain, and relationship distress.

- Through the Suicide Prevention Program uses an integrated approach to ensure that Veterans at risk for suicide have ready access to high-quality care. The program includes local and national outreach efforts; suicide prevention and crisis intervention education; collaboration with public/private partners; access points for Veterans in crisis; two hubs of expertise in the area of suicide prevention research; and an enhanced care delivery system for Veterans at high risk for suicide.

National Center for Health Promotion and Disease Prevention

Overview

National Center for Health Promotion and Disease Prevention (NCP/10P4N), a field-based office in Durham, North Carolina, promotes personalized, proactive, Veteran-driven care by advocating for health promotion, disease prevention and patient health education, and advising VA leadership on evidence-based health promotion and disease prevention policy.

Functions and Activities

- Provides programs, education, resources, coordination, guidance, and oversight for field staff to prevent illness and enhance health, well-being, and quality of life for Veterans.
- Trains and supports field-based prevention staff, including facility-level Health Promotion and Disease Prevention Program Managers, Health Behavior Coordinators, Veterans Health Education Coordinators, MOVE! Program Coordinators, and VISN-level health promotion and disease prevention leaders.
- Provides facility support for preventive care by training and coaching clinical staff in patient-centered communication, health coaching, and motivational interviewing, and assists clinical staff in the integration of health education, health promotion, and disease prevention resources and services into care.
- Coordinates the development, approval, and dissemination of VHA Clinical Preventive Services Guidance Statements, which inform clinical staff about recommendations regarding clinical preventive services.
- Partners with colleagues within and outside of VA to identify and disseminate personalized health education, health promotion, disease prevention resources, and tools for Veterans and VA staff, including the Veterans Health Library and the health risk assessment called the “Healtheliving Assessment.”
- NCP is responsible for MOVE!, VHA’s weight management program. MOVE! is a comprehensive, evidence-based, population-approach to multidisciplinary weight management and is available to Veterans via in-person visits, telephone lifestyle counseling, home telehealth, clinical video teleconferencing, and the recently-released MOVE! Coach mobile app.
- Produces a variety of communication products, including quarterly newsletters, annual highlights reports, staff and patient education materials, training videos, websites, and other products.

- Conducts clinical demonstration projects for new clinical programs related to health promotion and disease prevention.

Pharmacy Benefits Management Services

Overview

Pharmacy Benefits Management (PBM/10P4P) Services is located in Washington, DC, and has several programs decentralized throughout the country to provide organizational and clinical leadership to VHA Pharmacies, as well as support to other healthcare providers to facilitate the highest quality care to Veterans by ensuring safe, effective, and medically necessary management of medications. This is accomplished by creating a practice environment that fosters education, professional development, progressive practice initiatives, and innovative technologies to ensure consistent, accurate and reliable medication distribution and information systems.

Functions and Activities

- Operates the VA Consolidated Mail Outpatient Pharmacy (CMOP) with facilities located in: Leavenworth, Kansas; Tucson, Arizona; Chelmsford, Massachusetts; Dallas, Texas; Murfreesboro, Tennessee; Hines, Illinois and Charleston, South Carolina. The CMOP processed 119 million outpatient prescriptions in fiscal year 2015, approximately 80 percent of all outpatient prescriptions dispensed by VHA. In addition, CMOP fills prescriptions for 43 Indian Health Service sites, and the CHAMPVA program.
- Develops annual list of initiatives that target cost avoidance while maintaining high-quality pharmaceutical care, through the PBM National Pharmacy Efficiency Program. The voluntary initiatives were utilized by the VISNs and medical facilities in their pharmacy cost avoidance plans.
- Responsible, through the PBM's Formulary Management, for coordinating the VA National Formulary management process, with the Medical Advisory Panel and VISN Pharmacist Executive Committee.
- VAMedSAFE tracks and evaluates high-risk and high-volume agents and including New Molecular Entities with potential risk in the Veteran population. This program maintains VA's national drug safety program with an emphasis on integrated database utilization, communication, and education.
- Manages the configuration, maintenance, and activation of caches to be used in response to natural disasters, catastrophes, terrorist attacks, or weapons of mass destruction events through Emergency Pharmacy Service (PBM EPS). PBM EPS manages readiness of mobile pharmacy assets to be deployed for the immediate prescription services for Veterans displaced or affected by a catastrophic event.
- Pharmacy Re-engineering (PRE) and Clinical Informatics, in partnership with the Office of Information Technology (OIT) PBM, deployed its clinical decision support system for Drug Interactions, Medication Order Check Healthcare Application (MOCHA).
- Operates and oversees the PBM VA National Drug File (VA NDF), the Nation's largest government developed open-source system for drug terminology; this content is used for

medication ordering and management at the VA and other healthcare systems and provides that information to the National Library of Medicine. The system is currently being replaced with the Pharmacy Product System that will improve operational efficiency, medication ordering and dispensing, and patient safety.

- Established the Academic Detailing Program in VISN 21/22 for Mental Health Initiatives, a joint initiative between PBM and Mental Health Service, to guide evidence-based prescribing in mental health. Multiple initiatives are improving care to patients with mental health conditions.
- Meds by Mail (MbM) program coordinates the CHAMPVA Medications by Mail Program. MbM, with locations in Cheyenne, Wyoming and Dublin, Georgia, coordinates the Virtual Pharmacy Services (VPS) Program to remotely process outpatient prescriptions for VA pharmacies.
- The Pharmacy Residency Program Office (PRPO) oversees the nationwide strategic planning of pharmacy residency programs. To support VHA strategic initiatives, PRPO has expanded the Mental Health Pharmacy Residency programs and with the highest percentage of Board Certified Psychiatric Pharmacists in the country is now the largest trainer of Mental Health Pharmacy residents. Currently, the PRPO has over 575 residents, which includes specialty training in Geriatrics, Mental Health, Oncology, Pharmacy Administration, Infectious Disease, Internal Medicine, and Ambulatory Care.
- Provides technical guidance to VA medical facilities (VAMCs) on pharmaceutical compounding, and pharmaceutical waste and hazardous drug management through the Pharmaceutical Compounding and Management Standards Program Office.
- Collaborates with VHA program offices, Indian Health Services, and DoD's Medication Use Crisis Virtual Conference Series through the VA Medication Reconciliation Initiative. Joint Initiatives including the Medication Information Management Education Module and the National Alliance for Patient Medication Information Standardization.
- The Pharmacy Recruitment and Retention Office (PRRO) provides guidance and support to VA medical facilities facing pharmacy recruitment and retention challenges. The Clinical Pharmacy Practice Office seeks to streamline VHA's clinical pharmacy program while developing standardized pharmacy practice models, educational initiatives, and projects that assess the impact of clinical pharmacy interventions and penetration.
- Provides organizational management of Opioid Safety Initiative Dashboard that contains key metrics which are routinely monitored, trended and reviewed by senior leaders.

Post Deployment Health Service

Overview

Post Deployment Health Service (PDHS/10P4Q) encompasses three distinct programs - Environmental Epidemiology, Environmental Health - Post-911 and Environmental Health - Pre-911. The Post-911 and Pre-911 programs govern registry programs related to environmental and occupational exposures of U.S. Veterans during military service, including Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), Gulf War, Vietnam, World War II (WWII) and Atomic Veterans activities. The Epidemiology Program conducts surveillance and studies on Veterans' health and health care. Findings from these

research studies help health professionals and policymakers, including VA and Congress, improve health care practices and policies for Veterans. SMEs in all three programs work together to help develop policy recommendations for the Secretary based on scientific reviews of health outcomes and military-related exposures. In addition, PDHS coordinates the work of the War Related Illness and Injury Study Center (WRIISC). This center, which has three locations, provides specialty clinical care to Veterans with deployment-related symptoms, conditions, illnesses, and injuries, including those that are difficult to diagnose or explain.

Functions and Activities

- Performs surveillance and epidemiological studies of the health of Veteran populations to determine adverse health outcomes associated with deployment and military service in general.
- Reviews scientific and medical literature in order to recommend healthcare policies related to the health outcomes of military exposures to the Secretary of Veterans Affairs.
- Coordinates with DoD through the Deployment Health Working Group on all potential environmental and occupational hazards affecting Veterans' health to facilitate data sharing and coordinate policy development.
- Develops, maintains, updates, and evaluates VA health registries, including the Persian Gulf War, Agent Orange, Ionizing Radiation, and Airborne Hazards and Open Burn Pit registries.
- WRIISC is charged with developing research related to causation, diagnosis, and treatment for such Veterans; evaluation of Veterans with hard-to-diagnose illnesses; education for Veterans and health care providers, both VA and non-VA, who work with these Veterans; and health risk communication to Veterans and their families on deployment related illnesses and injuries.

Rehabilitation and Prosthetic Services

Overview

Rehabilitation and Prosthetic Services (10P4R) oversees program and policy development for rehabilitation services for VHA, coordinating the provision of the full continuum of medical rehabilitative and prosthetic services to promote the health, independence, and quality of life for Veterans with disabilities. This office aligns clinical expertise, clinical and practice guidance, and specialized procurement resources to provide comprehensive rehabilitation, prosthetic and orthotic services across the VHA health care system in the most economical and timely manner.

Functions and Activities

- Advises the Under Secretary for Health, Deputy Under Secretary for Health for Policy and Services, Assistant Deputy Under Secretary for Health for Patient Care Services, VHA Program Offices, the field, and other governmental agencies on issues related to Rehabilitation and Prosthetic Services.
- Administers program and policy development for national programs and services provided under Rehabilitation and Prosthetic Services.
- Provides comprehensive Audiology and Speech Language Pathology care services to Veterans with hearing loss, tinnitus, and balance in more than 400 sites of care by more than 1100

audiologists. Auditory system disabilities (including hearing loss and tinnitus) are among the most common service related disabilities in every period of service since WWII.

- Provides guidance, advice, and oversight on all matters related to blind and vision rehabilitation programs for Veterans and Service members with visual impairment (low vision, legally blind, and blind), to restore independence and assist them in adjustment and re-integration into home and community life.
- Provides evidence-based Chiropractic clinical services as part of the standard Medical Benefits Package available to all enrolled Veterans which support Pain Management, Rehabilitation, and other medical services, and managed consistent with both VA and external guidelines in delivering appropriate treatment options.
- Leads the National Veterans Special Programs and Special Events to promote adaptive sport, creative art therapy, and recreation programs through local, regional and national events, to help Veterans redefine their capabilities, establish rehabilitative goals, and achieve their full potential in a therapeutic environment through their training for, and participation, in these events.
- Provides guidance, advice, and oversight on all matters related to Orthotic and Prosthetic Clinical Services are delivered at more than 80 locations (or “labs”) across the country to design, fabricate, repair, and adjust the Veteran’s orthotic and prosthetic devices. All O&P laboratories maintain full accreditation by the American Board for Certification in Orthotics, Prosthetics and Pedorthics.
- Provides medical and rehabilitative preventative strategies, and acute and chronic management of disorders that alter functional status. This treating specialty delivered by physicians and other core disciplines (physical therapy, occupational therapy, kinesiotherapy) emphasizes restoration and optimization of function through physical modalities, therapeutic exercise and interventions, adaptive equipment, modification of the environment, education, and assistive devices.
- Comprehensive provider of prosthetic devices and sensory aids, leading the world, and includes any devices that support or replace a body part or function. VA provides all clinically appropriate and commercially available, state-of-the-art prosthetic equipment, sensory aids and devices to Veterans that cross the full range of patient care. Such items include: artificial limbs and bracing, wheeled mobility and seating systems, sensory-neural aids (e.g., hearing aids, eyeglasses), cognitive prosthetic devices, items specific to women’s health, surgical implants and devices surgically placed in the Veteran (e.g., hips and pacemakers), home respiratory care, recreational and sports equipment.
- Provides therapeutic services through incorporating recreational, creative arts, and leisure activities that promote health and wellness, and reduce or eliminate the activity limitations and restrictions caused by an illness or disabling condition. These services are directed to such goals as sensory integration, ambulation, diminishing emotional stress, muscular dysfunction reorientation, and providing a sense of achievement and progress that enhances independence.

- Leads the integrated nationwide Polytrauma System of Care (PSC) and Traumatic Brain Injury (TBI) Program in a network of over 110 facilities with specialized rehabilitation programs for Veterans and Service Members with TBI and Polytrauma. Provides guidance, advice, and oversight on all matters related to Rehabilitation services within the PSC are coordinated across four tiers of care based on the needs of the Veteran.
- Provides patient-centered, lifelong, holistic care and care coordination for the Amputation System of Care to Veterans and Service Members with an amputation through an integrated, tiered system of care, including regional Amputation Centers, Amputation Network Sites, and over 100 fully integrated amputation specialty clinic teams across VHA.
- Ensures early intervention for Veterans or Service Members whose vision loss results from progressive diseases like age-related macular degeneration, diabetic retinopathy, and glaucoma, as well as those whose vision loss results from the wounds and trauma of war through the Blind Rehabilitation Care Continuum of care. This continuum of care closely aligns Blind Rehabilitation Services, VA Optometry, and VA Ophthalmology to deliver the care coordination and services that are most appropriate for the patient's needs, including Visual Impairment Service Team Coordinators, Blind Rehabilitation Outpatient Specialists, Inpatient Blind Rehabilitation Visual Impairment Services, and Low Vision Clinics.
- Provides a comprehensive Driver Rehabilitation Program for Veterans with a wide range of physical and mental disabilities, which includes evaluation, driver simulation, behind the wheel training, equipment recommendation, assessment and inspection, and assistance with the various state motor vehicle licensing requirements.
- Provides the necessary adaptive equipment and training to disabled Veterans or Service Members to enable operation of a motor vehicle safely, and permit access to and from the vehicle through the Automobile Adaptive Equipment Program.
- Manages the Home Improvement and Structural Alterations Program that offers a grants that provide medically necessary improvements and structural alterations to a Veteran/Service member's primary residence for purposes of allowing entrance to or exit from their primary residence, use of essential lavatory and sanitary facilities, accessibility to kitchen or bathroom sinks or counters, and improving plumbing or electrical systems made necessary due to installation of medical equipment in the home.
- Provides an annual clothing allowance to Veterans who have a service connected disability or condition that requires them to wear or use a prosthetic or orthopedic device that wears or tears clothing, or a service connected skin condition and skin medication is prescribed, which causes irreparable damage to the Veteran's outer garments.

Integrative Health Coordinator (10P4U)

Overview

Integrative Health Coordinator (10P4U) serves as a subject matter expert on issues involving the use of Complementary and Integrative Health modalities as a means to improve the health and well-being of Veterans.

Functions and Activities:

- Works as part of the Integrative Health Coordinating Center (a collaboration with the Office of Patient Centered Care and Cultural Transformation) to identify Complementary and Integrative Health practices that should be considered for incorporation into VHA, and to facilitate their implementation within VHA.
- Assists in the promotion of research into areas of Complementary and Integrative Health that may be of benefit to Veterans.

*Population Health***Overview**

Population Health (10P4V) provides leadership in applying a public health approach to identifying, measuring, and assessing Veteran populations with a focus on non-health care determinants of health, variation in measures, and tools to support population management.

Functions and Activities

- Provides leadership and guidance on identification and measurement of the health status of Veterans, including those who choose not to receive health care from VHA.
- Leads the use of social and non-health care data to understand the overall health of the Veteran population.
- Leads the development of broad-based reports on specific populations to improve care for Veterans.
- Provides quantitative and qualitative analysis to other national program offices pertaining to health outcomes of defined Veteran populations to improve care for Veterans.
- Engages with internal partners to analyze and plan interventions for Veteran populations.
- Leads the development and use of the local and national Clinical Case Registry program for population health management.

*Women's Health Services***Overview**

Women's Health Services /10P4W oversees program and policy development for women's health in VHA and provides strategic support to implement positive changes in the provision of care for all women Veterans. WHS works to ensure that timely, equitable, high quality, comprehensive health care services are provided in a sensitive and safe environment at VA facilities nationwide. WHS programs include comprehensive primary care, women's health education, reproductive health, communication, and partnerships.

Functions and Activities

- Transforms health care delivery for women Veterans using a personalized, proactive, patient-centered model of care.
- Develops, implements, and influences VA health policy as it relates to women Veterans.

- Ensures a proficient and agile clinical workforce through training and education.
- Develops, seamlessly integrates, and enhances VA reproductive health care.
- Drives the focus and sets the agenda to increase understanding of the effects of military service on women Veterans' lives.

National Health Physics Program

Overview

National Health Physics Program (NHPP/10P4X) provides regulatory oversight for radiation safety while providing health and medical physics consultation throughout the Veterans Health Administration (VHA). NHPP assists Radiation Safety Officers and other interested facility staff by making relevant health physics, medical physics, and regulatory information easily and readily accessible on a website, site visits to impacted facilities, and Webinar training. The scope of the information for consultative assistance includes providing regulations, directives, and standards from the VHA, Nuclear Regulatory Commission (NRC), American College of Radiology, The Joint Commission, and pertinent guidelines from other U.S. or international organizations. Furthermore, best practices, lessons learned, and model procedures are provided to enhance facility-level capability for keeping radiation exposures to employees, patients, and the public as low as reasonably achievable.

Functions and Activities

- NHPP is the primary VHA office for implementing an NRC master materials license. NHPP issues permits and inspects VHA facilities using radioactive materials.
- Provides health and medical physics support for other uses of ionizing radiation and reports to the National Radiation Safety Committee.
- Partners with the Office of the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value (ADUSH QSV) to help manage overall VHA organizational risk, and facilitate an integrated, industry-standard approach to compliance with applicable laws, regulations, and standards while identifying non-compliant practices that require improvement.

Lesbian, Gay, Bisexual and Transgender Program

Overview

The Lesbian, Gay, Bisexual and Transgender Program (LGBT/10P4Y) oversees program and policy development to ensure high-quality patient-centered care for LGBT Veterans in VHA. VA is committed to creating a welcoming environment for all Veterans, including special populations such as LGBT Veterans. LGBT Veterans face increased health risks and unique challenges in accessing quality healthcare. The LGBT Program provides policy recommendations, provider-education programs, and clinical services to support personalized, pro-active, patient-driven healthcare for LGBT Veterans. In addition, the LGBT Programs works to ensure that quality care for LGBT Veterans is provided in a sensitive, safe environment at VA health facilities nationwide.

Functions and Activities

- Advises the Under Secretary for Health, VHA Program Offices, other governmental agencies, and field on issues related to LGBT Veterans and LGBT Veteran healthcare. Partners with the Office

of Academic Affiliations and Mental Health Services to provide oversight for Postdoctoral Psychology Fellowship Training Positions with an emphasis on Inter-professional Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Care for Veterans at nine VHA facilities.

- Oversees development and dissemination of VHA policies to insure quality care for LGBT Veterans. Reviews VHA policies to ensure inclusive language relevant for LGBT Veteran care, including non-discrimination policies, hospital visitation, caregiver education and the definition of family at VHA. Coordinates with other offices to ensure clear, consistent policies are centered on LGBT Veterans' needs.
- Develops and disseminates ongoing educational programs for VHA staff about best practices in LGBT healthcare. In addition, VA will soon collect self-identified gender identity for all Veterans. The LGBT program leads a workgroup to develop training and resource materials to assist VHA, VBA, and NCA employees with this change.
- Works to increase clinical capacity and improve cultural competency in transgender health through two nationwide clinical consultation programs (SCAN ECHO, E-consultation). Any VHA provider anywhere in the system can attain VHA expert consultation on transgender healthcare through the inter-facility transgender E-consultation program; SCAN ECHO trains interdisciplinary clinical teams in VHA facilities via teleconferencing.
- Develops and disseminates products to help VHA facilities create a more welcoming environment for LGBT Veterans. Develops and maintains online SharePoint sites for LGBT Veteran healthcare. Partnered with the Office of Health Equity to develop and disseminate an external fact sheet to share information about the services and policies available for LGBT Veterans.

Occupational Health Services

Overview

Occupational Health Services (10P4Z) provides policy and services to promote a healthy and safe work environment, reduce absenteeism from chronic disease and work-related injury, prevent violence and support meaningful work in VHA.

Functions and Activities

- Develops, maintains, and analyzes databases for absenteeism, employee accident and injury tracking, medical surveillance, occupational safety, and occupational/employee health outcomes.
- Provides support and policy for the Employee Occupational Health (EOH) clinicians and clinics related to infectious disease outbreaks, employee influenza program and medical exams for employees.
- The Employee Health and Well-Being (EHWB) provides staff with the educational and training opportunities and resources needed to reduce the incidence of preventable illness, injury, and impairment. The program supports healthier lifestyles for employees, provides regulatory oversight for the VA Drug-Free Workplace program and prevention of provider impairment.

- Supports policy, training, technical expertise and evaluation of technology for enabling patient mobility and reducing injury to staff through the Safe Patient Handling and Mobility (SPHM).
- Through the Workplace Violence Prevention Program (WVPP) manages the Prevention and Management of Disruptive Behavior (PMDDB) training program, the Sexual Assault Prevention policy and workgroup, the Patient Record Flagging (PRF) and Disruptive Behavior Committee (DBC) policies.
- Develops policy and procedural guidance, communications, and training to VHA facilities on the operations of Federal workers' compensation programs through the Workers Compensation Program (WCP). WCP is delegated authority by the DUSHOM to provide program oversight, evaluate regulatory compliance and to report findings to the DUSHOM for enforcement.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV

Connected Care

Overview

In FY 2016, VA Telehealth Services and the Connected Health Office merged to create the Office of Connected Care (10P8) to further enhance the delivery of personalized, proactive, patient-driven health care to Veterans. The Office of Connected Care's principal focus is delivering health IT solutions that increase a Veteran's access to care, and supports a Veteran's participation in their own health care. This includes developing and delivering virtual and digital technologies that help Veterans communicate with their VA care teams and coordinate, track and manage their health care. These technology and health solutions are delivered through four Connected Care programs: VA Telehealth Services, My HealtheVet, the VHA Innovation Program and VA Mobile.

Functions and Activities

- Works collaboratively to standardize and promote the use of virtual and digital products, interfaces and development tools.
- Focuses on improving the user experience for Veterans and health care professionals across platforms through the use of build in user-centered design, context and role-based workflow, data mining, and decision support/analytic capabilities that improve personalization and tailoring of information across numerous devices/user touch points.
- Through VA Telehealth Services uses health informatics, disease management and telehealth technologies to target care and case management to bring care to Veterans wherever they may be.
- Manages VA's online personal health record, My HealtheVet, and associated functionalities: VA Blue Button, VA Open Note and VA Secure Messages; creates and oversees related programs focused on Veterans' health and wellness.
- Fosters the emergence of health care innovations, including solicitation and promotion of innovative ideas via employee and industry competitions through the VHA Innovation Program.

- Leads VA Mobile development and enhances and oversees VA's Veteran- and VA staff-facing web and mobile applications.

Authorities

38 U.S.C. Part V, 73

The Privacy Act of 1974

The Paperwork Reduction Act (PRA) of 1980

The Health Insurance Portability and Accountability Act (HIPAA) of 1996

The Government Paperwork Elimination Act (GPEA) of 1998

The Electronic Government Act of 2002

The Federal Information Security Management Act (FISMA) of 2002

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009

The Patient Protection and Affordable Care Act (PPACA) of 2009

Freedom of Information Act (FOIA)

The Clinger-Cohen Act of 1996 (Information Technology Management Reform Act)

5 U.S.C. 552

38 U.S.C. 7332

38 U.S.C. 5705

EO 12862

EO 13571

29 U.S.C. 794d, § 508

Office of Research and Development

Overview

The VHA Office of Research and Development (ORD/10P9) advances knowledge to improve each Veteran's health and well-being through preclinical, clinical and health services, and rehabilitative research. ORD aspires to discover knowledge, develop VA researchers and health care leaders, and create innovations that advance health care for our Veterans and the Nation. The Office of Research and Development is located in VA Central Office (Washington, DC). ORD is administratively managed in four research service areas and several supporting program offices. VA research is an intramural program; VA investigators who apply for funding from ORD are located at VA facilities across the country.

Functions and Activities

- Funds scientifically meritorious, Veteran-centric research in many areas to advance our knowledge. High-priority areas include Precision Medicine, Traumatic Brain Injury, Posttraumatic Stress Disorder, women's health, mental health, Gulf War Veterans' Illnesses, and prosthetics.
- Manages a rigorous peer review process that ensures all VA research meets the highest standards of scientific excellence.
- Applies advances in scientific knowledge to create, test, compare, and implement new treatments, technologies, education modules, and models of care so that Veterans receive the most effective individualized care solutions.

- Facilitates rapid translation of research findings into practice with Quality Enhancement Research Initiative (QUERI).
- Enhances the interface between VA health care providers and policy decision-makers to identify key research questions for comparative effectiveness research, and enhances the Evidence-based Synthesis Program (ESP) to improve development of Veteran-focused research syntheses.
- Ensures a state-of-the-art research enterprise with a culture of professionalism, collaboration, accountability, and the highest regard for research volunteers' safety and privacy.
- Recruits, trains, and retains the highest-caliber investigators and staff, and nurtures their continuous development as leaders in their fields. Approximately 60 percent of funded VA investigators also provide direct patient care.
- Through Career Development Program focuses on attracting scientists who are within 5 years of completing their last training, to advance their research training and their clinical skills in areas critically important to advancing health care of Veterans.
- The Research Career Scientist Program rewards non-clinician Ph.D. scientists who distinguish themselves through scientific achievement and contributions to the VA research program by providing a salary award. This program ensures the maintenance of the highest possible standard of scientific excellence within the VA and provides a scientific resource for VA clinician-investigators.
- Explores all phases of Veterans' health care needs through three research services that form a cohesive approach to research and development:
 - **Biomedical Laboratory Research and Development (BLR&D):** Conducts preclinical research to understand life processes from the molecular, genomic, and physiological level in regard to diseases affecting Veterans. BLR&D includes research on animal models and investigations of tissues, blood, or other biologic specimens from humans, but does not include studies with people.
 - **Clinical Science Research and Development (CSR&D):** Focuses on clinical trials and other research involving human volunteers to study new treatments, compare existing therapies, and improve clinical practice and care. The Cooperative Studies Program within this division is responsible for planning and conducting VA's large multicenter clinical trials and epidemiological studies on health issues vital to our nation's Veterans.
 - **Health Services Research and Development (HSR&D):** Supports research to improve the delivery of health care to Veterans. Among the areas studied are quality and organization of care; patient access and outcomes; and cost-effectiveness. HSR&D's Quality Enhancement Research Initiative (QUERI) is designed to translate research findings into advancements in Veterans' care.

Provides administrative support for research through supporting program offices:

- **Program for Research Integrity, Development, and Education (PRIDE):** Responsible for policy development and guidance for human research protection throughout the VA, training and

education in human research protection, accreditation of all VHA Human Research Protection Programs, and creating and implementing the VA Central Institutional Review Board.

- **Technology Transfer Program (TTP):** Responsible for facilitating the commercialization of VA inventions to benefit Veterans and the American public. This includes educating VA employees concerning their rights and obligations regarding inventions, coordinating applications for patents, actively marketing and licensing VA inventions, and developing and implementing policies that govern the relationship among employee inventors, academic affiliates, local VA facilities, and industry.
- **Non-Profit Program Office (NPPO):** Provides oversight and guidance for the VA-affiliated research and education corporations.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV

Office of the Deputy Under Secretary for Health for Operations and Management

Overview

The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) leads VHA operations and ensures it continues to be the benchmark for health care excellence and value through the clinical and administrative services we provide to care for Veterans and their families.

The Office of the DUSHOM operates VHA health care systems, medical centers, systems of clinics, and outpatient clinics. VHA's coverage area is divided into 19 VISNs, each a shared system of care working together to better meet local health care needs and provide Veterans greater access to care. The DUSHOM is responsible for 19 other VHA clinical and administrative program offices that ensure that VHA program policies and regulations are executed and supported to fulfill the operating needs of VHA field operations.

Functions and Activities

- As the focal point for the flow of information and guidance between VACO and the field, the Office of the DUSHOM provides operational direction and guidance to each of the 19 VISNs.
- Coordinates and directs a wide range of operational matters dealing with VISN planning, congressional issues, Veterans Service Organizations (VSOs), the media, Veterans, and families.
- Collaborates with VISNs and VHA congressional advisory offices to mediate, advocate for, and resolve incoming congressional issues and priorities at all levels of the organization.
- In collaboration with the 19 Network Directors, the Performance Management Work Group (PMWG) and other VHA performance management offices, DUSHOM establishes and updates metrics that hold VISNs accountable to standards for the services they provide.
- Serves as the principal advisor to the USH and other executive leadership within VHA on matters pertaining to VHA field operations in order to closely coordinate and maintain solid working relationships with other VA/VHA offices to advance VA/VHA initiatives.

Authorities

38, U.S.C. 73 and applicable Subchapters I-IV

P.L. 111-8

P.L. 99-166 II

VHA Directive 2006-031

VHA Directive 2010-27

VHA Handbook 1030.02

VHA Handbook 1101.10 "Patient Aligned Care Teams"

P.L. 106-117, The Veterans Millennium Health Care Benefits Act

38 U.S.C. 1710B, 1717, 1720C

38 U.S.C. 1718

45 CFR 164.512

VHA Handbook 1004.1, 1160.01, 1160.02, 1605.1

21 U.S.C. 321

42 U.S.C. 362

38 U.S.C. 1712

38 CFR 17.160-17.166

VHA Executive Decision Memo of March 7, 2011, "Activation of the Office of Disability and Medical Assessment"

P.L. 112-10 for FY2011

38 U.S.C. 8102

38 U.S.C. 8103

38 U.S.C. 8104

38 U.S.C. 8131-8135

38 U.S.C. 8153

VAAR 801.695-2

EO 12656

PDD-67

38 U.S.C. § 1785

HSPD 10

HSPD 18

HSPD 20

HSPD 21

Office of the Assistant Deputy Under Secretary for Health for Administrative Operations**Overview**

The Office of the Assistant Deputy Under Secretary for Health for Administrative Operations (ADUSH/AO/10NA) is the national leader in health care systems for administrative and operational support. It creates operational excellence that is measurable and value-added. The Office of ADUSH/AO serves Veterans and their families by delivering improved logistics, procurement, capital, facilities, and issues management through VISNs, VHA facilities, and directly to Veterans and their families. The office comprises nine components that strive to lead VHA administrative operations towards excellence using the guiding principles of financial stewardship; customer-centric services for our Nation's Veterans; assurance of a learning environment for employees; and demonstrating inclusion through a respectful and diverse workforce.

Functions and Activities

Serves as the principal advisor to the DUSHOM and to the Under Secretary for Health. The ADUSH-AO provides advice and recommendations related to program areas of responsibility, including resolving complex challenges and issues that can affect the entire array of VHA's health care system and operations. Primary activities include:

- Providing oversight for managing VHA's procurement program assigned to the Head of Contracting Activity (HCA). HCA has authority to appoint and terminate contracting officers, and will lead the transformation of VA's supply chain, which is one of VA's Top 12 Breakthrough Priorities.
- Identifying and establishing national priorities for the overall healthcare system, particularly those programmatic areas of responsibility concerning performance management and financial and operational goal setting.
- Integrating program office operations to ensure a collaborative focus on the Veteran's experience.
- Evaluating and leveraging inputs from external groups including Congress, media and Veterans service organizations in effort to shape DUSHOM and program offices' perspectives, behaviors and outputs involving communications and community engagement.
- Orchestrating fiscally responsible and efficient procurement, implementation and management of medical technologies, systems, capital assets and equipment, including Environment of Care, construction, SOARD, RTLS and other tools and systems.

Authorities

VA Acquisition Regulation 801.695-3

Office of Emergency Management

Overview

VHA's Office of Emergency Management (OEM/10NA1) develops and implements the VHA Comprehensive Emergency Management Program (CEMP). VHA OEM supports field operations from its headquarters in Washington, DC and Martinsburg, West Virginia. VHA OEM field staff provides direct support to VHA facilities via regional and area emergency managers stationed at VISNs and VAMCs throughout the country.

Functions and Activities

- Utilizing CEMP, VHA OEM ensures the continuity of healthcare operations during disasters and other contingencies.
- Provides direct program support to the Law Enforcement officers via the office of the VHA Chief of Police.
- Directly supports VHA facilities before, during and after incidents and events by providing subject matter expertise in the development, evaluation and execution and of response plans.

- Coordinates responsibilities under the National Response Framework in preparation for and response to a national disaster.
- Provides strategic guidance and policy development for comprehensive emergency management.
- Provides direct decision support to senior leadership during crisis management via the Integrated Operations Center.

Authorities

38 U.S.C. § 501, 1784, 1785, 7328, 7301(b), 8110, 8111A, 8117, 8125, 8153

42 U.S.C. § 5121-5208, 300hh-300hh31

Presidential Policy Directive (PPD) #8

Homeland Security Presidential Directive (HSPD) #8

Homeland Security Presidential Directive (HSPD) #20

Homeland Security Presidential Directive (HSPD) #5

Procurement and Logistics Office

Overview

The Procurement and Logistics Office (P&LO/10NA2) provides contracting support that includes supplies, construction, medical services, and leasing for VHA'S 19 networks. We provide operational oversight for VHA's Supply Chain Operations and serves as the primary agent for designing, developing, and deploying logistics and program management activities. Our procurement and logistics operations assure VHA clinicians have timely access to high quality goods and services at prices that reflect the purchasing volume of VHA. In addition, P&LO provides service through its major organizational components: Chief Operating Office, Office of Logistics, Office of Procurement, Service Area Offices (SAO): SAO East, SAO Central, and SAO West, VHA Special Projects Office, and the VHA Veterans Service Center (VSC) located in Cleveland, Ohio.

Functions and Activities

- The Procurement and Logistics Office awards contracts in support of VHA requirements including healthcare resources; it monitors procurement metrics to ensure procurement actions occur within specified time periods and in accordance with Federal and VA acquisition regulations (does not include national contracts, Federal Supply Schedule contracts, and construction above \$10 million or information technology contracts above \$100,000).
- Identifies a Chief P&LO Officer, who is assisted by the Deputy Chief Procurement Officer to whom the three Heads of Contracting Activity (HCAs) report. The HCAs, located in Pittsburgh, Pennsylvania (East), Murfreesboro, Tennessee (Central), and McClellan Park, California (West) are responsible for all contract actions completed by VHA procurement personnel as well as for the administration of contracts and/or real property leases under delegations issued by Office of Acquisition, Logistics and Construction contracting activities.
- Oversees the VHA Government Purchase Card Program.
- Issues logistics guidance and provides oversight of logistics activities conducted by VHA VISNs, and VAMCs.

- The VHA Service Center, located in Independence, Ohio, provides life-cycle HR, payroll, travel and fiscal services for reimbursable program office customers and contracting personnel.
- Provides security background services for contractor personnel.
- The Special Projects Office provides information solutions to VHA stakeholders via integration of commercial off-the-shelf applications and mining existing legacy sources.

Authorities

VHA Directive 1081

VHA Directive 1730.1

VA Acquisition Regulations

Federal Acquisition Regulations

Office of Capital Asset Management and Engineering

Overview

The Office of Capital Asset Management and Engineering (OCAMES/10NA5) provides VHA's guidance, oversight, and technical support for capital initiatives and engineering operations. Programs within this Office include Major Construction, Minor Construction, Non-Recurring Maintenance (NRM), Clinical Specific Initiatives (CSI), Leasing, Sharing Use of Space, Enhanced Use Leasing, Energy, Fleet, Engineering Operations, and State Home Construction Grant Program.

Functions and Activities

- Provides professional engineering and capital expertise.
- Provides direction, guidance, and policy for capital and engineering programs.
- Develops budget requests for construction programs.
- Manages VHA's space inventory.
- Manages and prioritizes State Home Construction grant funding.
- Interpreting codes, regulations, policies, and standards for implementation.
- Oversees and monitors energy and fleet consumption.
- Provides support in capital, engineering operations, and emergency situations.
- Provides training for capital, engineering, energy, fleet, and State Home programs, policies, processes, and responsibilities.
- Provides VHA's guidance, management, and oversight regarding the Strategic Capital Investment of Planning (SCIP) process and VISN submissions.

*Veterans Canteen Service***Overview**

Veterans Canteen Service (VCS/10NA6), headquartered in St. Louis, Missouri, is responsible for making available reasonably priced merchandise and essential services for the comfort and well-being of Veterans enrolled in VA's Health Care System, their families, caregivers, employees, volunteers, and visitors. Canteens are located in VAMCs, CBOCs, OPCs, HCCs and VBAs.

Functions and Activities

- Serves as an internal VA resource for securing special purchases.
- Furnishes catering and other services on an ad hoc basis to Department personnel and recognized VSOs.

Authorities

P.L. #109-461, 1946,
38 U.S.C. § 78
VHA Handbook 1008.01

*Environmental Programs Service***Overview**

Environmental Programs Service (EPS/10NA7) is responsible for the development and governance of policies for the provision of a safe, sanitary, healing environment for VHA facilities and accompanying provisions of governance for those respective programs.

Functions and Activities

- Ensures that the following program functions are effectively implemented at each VA medical facility: environmental sanitation, integrated pest control, textile care management and processing, interior design, hazardous chemicals, waste management and recycling, and ground maintenance, and promote environmental and sustainable practices.
- Serves as the principal environmental advisor on policy development and technical support to the Office of the Under Secretary for Health.
- Develops quantifiable goals and objectives which measure continuous environmental improvement and monitors progress.

Authorities

Employee Uniforms – VHA Handbook 1850.04
Textile Care Management - VHA Handbook 1850.03
Clothing, Incidentals, and Services for Patients- Manual M-1, Part VII, 9
Sanitation Operations - Manual M-1, Part VII, 4
Interior Design Operations and Signage – VHA Handbook 1850. 05
Pest Management Operations – VHA Handbook 1850.02
Environmental Programs Service- VHA Directive 1850
Waste Minimization and Compliance Report (RCN 10-99-904) - VHA Directive 2009-065
Waste Management- M-1, Part VII 14

Textile Car Facility Operations- M-1, Part VII 6

*Occupational Safety and Health, and Green Environmental Management Systems***Overview**

The Office of Occupational Safety, Health, and Green Environmental Management Systems (GEMS) Programs (10NA8) provides policy, oversight, and technical support that enhances the safety and health of our employees, Veterans, and the public, and promotes protection of the environment. Programs within this office include Occupational Safety and Health, GEMS, Fire Protection and Life Safety, VA Fire Department Operations, Industrial Hygiene, Industrial Safety, Construction Safety, and Workers Compensation Compliance.

Functions and Activities

- Develops policy and provides oversight and technical support to reduce the incidence of occupational safety and environmental compliance deficiencies, and employee injuries.
- Works with VHA facilities, VISNs, the Office of General Counsel, and external oversight agencies to assist in the adjudication of regulatory enforcement actions and ensure fines and other actions taken by regulators are reasonable.
- Serves as the principal office to address untoward events of national significance related to occupational safety, environmental compliance, fire protection, and industrial hygiene. Proactively engages the development of appropriate risk assessment and mitigation strategies for these areas.
- Provides funding and project support to the field for Fire Protection, GEMS, and Safety programs.
- Works collaboratively and develops strategic partnerships with outside agencies, such as Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), the Environmental Protection Agency (EPA) and The Joint Commission to enhance VHA safety and compliance with healthcare accreditation standards.

Authorities

P.L. 88-206, Clean Air Act

P.L. 92-500, Clean Water Act

P.L. 93-523, Safe Drinking Water Act

P.L. 94-469, Toxic Substances Control Act

P.L. 96-510, Comprehensive Environ Response, Compensation, and Liability Act

P.L. 91-596, Occupational Safety and Health Act

*Healthcare Technology Management***Overview**

The Office of Healthcare Technology Management (HTM/10NA9) provides oversight to Biomedical Engineering and is responsible for national policies and directives related to medical equipment management and safety, while providing national leadership, consultation, and technology support.

Functions and Activities

- Applies engineering and managerial skills to Healthcare Technology Management, working integrally with clinical and administrative program offices and the VHA Biomedical Engineering workforce to deliver services at the point of care.
- Coordinates with clinical and administrative program offices on cross-cutting national initiatives to ensure consistent implementation and sustainment of healthcare technologies throughout VHA.
- Promotes patient safety by managing and communicating equipment recalls and safety alerts, monitoring performance of scheduled maintenance, designing and implementing medical device protection and information security practices, and promoting adoption of safety enhancements to medical equipment.
- Manages VACO review and approval of high-cost, high-tech medical equipment requests.
- Assists Facilities and VISNs with the selection, deployment, and management of Real Time Location System (RTLS) technologies at VHA facilities as well as development and dissemination of tools to support implementation.
- Designs and executes national performance monitoring and continuous program improvement across VHA Biomedical Engineering, including domains of employee learning and growth, customer satisfaction, process and quality, and financial performance. Facilitates spread of best practices through VISN and Facility Biomedical Engineering Programs.
- Drives development of medical technology strategic plans at the VACO- and VISN-levels, incorporating initiatives such as standardization of medical technology and coordinated recurring technical support to realize clinical and financial cost efficiencies.
- Supports Biomedical Engineering workforce development through horizontal training and education, and the recruitment of highly qualified professionals. Promotes succession planning through management of Technical Career Field program for Biomedical Engineering.

Authorities

US Law 21 CFR 820.100

21 CFR 807.81(a)(3)

21 CFR 814.39

Engineering & Occupational Safety and Health

Overview

The Center for Engineering & Occupational Safety and Health (CEOSH/10NA11) develops and provides products and services for VHA environment of care professionals to better comply with internal and external requirements, improve existing programs, and maintain awareness of programmatic changes.

Functions and Activities

- Serves as a technical resource for supported professionals throughout VA.

- Supports the development and implementation of program-related strategic and operational goals through the collection of data from field-focused databases and sources in order to improve VHA's ability to comply with regulations, executive orders, congressional requests, and other higher level VA and Federal policy/initiatives.
- Provides technical resources and tools used by VACO and the field to more efficiently and effectively implement programs; and, prevent/address untoward events of national significance related to supported programs.
- Supports the development of appropriate risk assessment and mitigation strategies for supported programs within VHA.

Authorities

VHA Directive 2012-009, VHA Vehicle License Plate Action Requests

VHA Directive 2009-039, Fire Incident Reporting

VHA Handbook 7701.02, Fire Department Services at VA Medical Centers and Domiciliaries

VHA Directive 7704, EMERGENCY EYEWASH AND SHOWER LOCATION (MANDATORY)

VHA Directive 7705, Management of Hazardous Chemicals

VHA Directive 2011-020, Automated Safety Incident Surveillance and Tracking System (ASISTS)

VHA Directive 7707, Green Environmental Management System (GEMS) and Governing Environmental Policy Statement

VHA Directive 2006-015, Benchmarking VHA Biomedical Engineering Operations

VHA Directive 1028, Electrical Power Distribution Systems

VHA Directive 1608, Comprehensive Environment of Care

VHA Directive 2006-007, Ensuring the Security and Availability of Potable Water at VHA Facilities

VHA Directive 1068 Recall of Defective Medical Devices and Medical Products Including Food and Food Products

VHA Directive 7703, Safety Management System (SMS) and Governing Safety Policy Statement

VHA Handbook 7701.01, Occupational Safety and Health (OSH) Program Procedures

VHA Directive 2006-033, OSHA Reporting and Recordkeeping of Work-Related Injuries and Illnesses Utilizing The Automated Safety Incident Surveillance and Tracking System (ASISTS)

VHA Directive 2008-062, BOILER PLANT OPERATIONS

VHA Directive 2009-044, Capital Resource Survey (CAPRES) Benchmarking of Environment of Care

VHA Handbook 1002.02, Minor Construction Program

VA Directive 0637, VA Vehicle Fleet Management Program

VA Handbook 0637, VA Vehicle Fleet Management Program

VA Directive 0063, Waste Prevention and Recycling Program

VA Handbook 0058, VA Green Purchasing Program

Office of Network Support

Overview

The Office of Network Support (10NA3) provides consultative advice to leadership at all levels of VA and VHA regarding sensitive and complex issues related to health care system operations and management.

Functions and Activities

- Serves as a central organizing unit between field facilities, VISNs, VAMCs, and VACO.

- Manages information flow and knowledge sharing with VHA program offices.

Office of Capital Asset Management and Engineering

Overview

The Office of Capital Asset Management and Engineering (OCAMES/10NA5) provides VHA's guidance, oversight, and technical support for capital initiatives and engineering operations. Programs within this Office include Major Construction, Minor Construction, Non-Recurring Maintenance (NRM), Clinical Specific Initiatives (CSI), Leasing, Sharing Use of Space, Enhanced Use Leasing, Energy, Fleet, Engineering Operations, and State Home Construction Grant Program.

Functions and Activities

- Provides professional engineering and capital expertise.
- Provides direction, guidance, and policy for capital and engineering programs.
- Develops budget requests for construction programs.
- Manages VHA's space inventory.
- Manages and prioritizes State Home Construction grant funding.
- Interpreting codes, regulations, policies, and standards for implementation.
- Oversees and monitors energy and fleet consumption.
- Provides support in capital, engineering operations, and emergency situations.
- Provides training for capital, engineering, energy, fleet, and State Home programs, policies, processes, and responsibilities.
- Provides VHA's guidance, management, and oversight regarding the Strategic Capital Investment of Planning (SCIP) process and VISN submissions.
- Develops quantifiable goals and objectives which measure continuous environmental improvement and monitors progress.

Office of Assistant Deputy Under Secretary for Health for Clinical Operations

Overview

The Office of the Assistant Deputy Under Secretary for Health for Clinical Operations (ADUSH/CO/10NC) is the Chief Operating Officer for field and ADUSH/CO program office clinical operations, including coordination with clinical and administrative leadership within the VISNs and collaboration with our partners in the Office of the Deputy Under Secretary for Health for Policy and Services (10P), and the Office of Patient Care Services (10P4). The Office of the ADUSH/CO strives to provide clinical services to Veterans and their families that serve as the benchmark for health care excellence and value.

Functions and Activities

- Monitors and ensures the integrity, quality, and value of clinical services at VHA facilities. It implements new policies to improve clinical services, integrates new and revised clinical services with other components of the health care organization, and executes clinical processes to improve health care delivery.
- Provides direction, guidance, and policy for capital and engineering programs.
- Supports clinical operations at the field level including consultation and support for clinical challenges, assistance in identifying additional resources and providing clinical expertise and policy implementation guidance.
- Supports clinical operations at the field level including consultation and support for clinical challenges, assistance in identifying additional resources and providing clinical expertise and policy implementation guidance.
- Coordinates and shepherds through Central Office clearance all Clinical Restructuring package.
- Assists with large scale disclosures and State Licensing Board actions.
- Works collaboratively with Public Health, Capital Asset Management and the field in relation to Legionella.
- Supports the Opioid Safety Initiative and OIG/GAO issues at the national, VISN, and facility levels.
- Organizational lead for Group Practice Management and Access.

VHA Homeless Programs Office

Overview

VHA Homeless Programs Office (10NC1) develops policy and coordinates the provision of VHA's programs and services for homeless Veterans in VISNs and VA medical centers. The office partners with stakeholders across the Agency, Federal agencies and local communities to develop programs and facilitate research supporting national efforts to end homelessness among Veterans.

Activities of the office support the vision of a systemic end to homelessness in communities, which means Veterans have access to permanent, sustainable housing; high quality health care and other supportive services, leading to a future where homelessness is prevented whenever possible or is otherwise a rare, brief, and non-recurring experience.

Functions and Activities

- Leads VA's efforts in operationalizing Federal efforts to end homelessness among Veterans put forth in Opening Doors, the Federal Strategic Plan to End Veteran Homelessness.
- Guides policy, planning and coordination of VA's programs and services for homeless and at risk Veterans by utilizing a comprehensive continuum of care focused on six pillars: Outreach and Education; Prevention; Treatment; Income, Employment and Benefits; Housing and Supportive Services; and Community Partnerships.

- Develops partnerships with, local, regional, and national organizations to expand access to meaningful employment, affordable housing and other needs of Veterans who are homeless and at-risk of homelessness and their families.
- Monitors and measures the integrity and effectiveness of VHA's homeless programs through various tools and provides technical assistance to VISNs and VA medical centers.
- Promotes best practices and evidence-based research related to services for homeless Veterans.
- Promotes recovery-oriented care for Veterans who are homeless or at-risk for homelessness by developing and disseminating evidence-based policies, programs, and best practices.

Authorities

38 U.S.C. §2031 and 38 CFR Part 63 (Health Care for Homeless Veterans Program)

38 U.S.C. §2003(b) (Housing and Urban Development (HUD)-Department of Veterans Affairs Supportive Housing (VASH) Program)

38 U.S.C. §2044 (Supportive Services for Veteran Families (SSVF) Program)

38 U.S.C. §§ 2011, 2012, 2061, and 2064 (Grant and Per Diem Program)

National Surgery Office

Overview

National Surgery Office (10NC2) develops and implements policy executes clinical oversight and provides guidance for all VHA surgical programs.

Functions and Activities

- Oversees the delivery of surgical care by VHA to enhance operations.
- Maintains clinical oversight of the established VHA surgical programs, surgical outcomes and surgical outcomes data analyzed for research purposes.
- Develops and implements national policy and guidance for surgical programs.
- Provides support for the national delivery of transplant and related services.

Authorities

VHA Handbook 1102.01 and 38 U.S.C. §7301(b)

Office of Primary Care Operations

Overview

Office of Primary Care Operations (10NC3) facilitates the delivery of quality-oriented, efficient, timely, safe and effective primary care within VHA facilities.

Functions and Activities

- Deploys and executes processes that enable and enhance the delivery of primary care and assesses new, revised, and existing primary care clinical services.

- Integrates and coordinates primary care clinical services with other components of the health care organization.
- Measures and monitors the integrity, effectiveness, quality and value of VHA primary care.
- Investigates and identifies barriers impacting primary care delivery that are then brought to medical center and VISN leadership for action.

Interim Staffing Program

Overview

Aligned under the Office of Primary Care Operations is the Interim Staffing Program (ISP), which recruits and trains doctors, nurses, and other health care personnel for rapid deployment to fill primary care, compensation and pension, and nursing vacancies occurring anywhere within VHA. ISP services are expanding to include subspecialty clinicians to further support patient access to and transit through the care experience.

Functions and Activities

- Provides a resource of VHA- vetted and trained primary care physicians (PCP), compensation and pension (C&P) examiners, registered nurses, and other health care personnel to VHA facilities in need of staffing support at prices that are competitive with private sector temporary staffing agencies. PCPs appointed based on their qualification (i.e. education and experience) and needs of the Interim Staffing Program.
- Provides staff strongly aligned to Veterans health care and well-integrated into VA culture of health care excellence, minimizing the need to review, interview, and select from among untested applicants, thereby supporting Human Resource operations at subscribing facilities.
- Performs static credentialing and assists with non-static credentialing, orientation and training so that all staff arrive at subscribing facilities ready to work.
- Serves as a valuable asset to clinical recruitment, and permits rapid staff movement from temporarily-assigned to permanently-employed status at subscribing facility without penalty.
- Reliable support for facilities in need of PCP or C&P examiner coverage; serves as a contingency plan for addressing lengthy wait times and/or emergency staff for natural, national, or local disasters. ISP clinicians have been among the first-responders to active threat situations at the VHA facilities.
- Serves as a laboratory to develop and test innovation in recruitment, training, deployment, and funding just-in-time staffing for persistent and unpredictable hiring challenges.

Authorities

Deputy Under Secretary for Health Operations Management Executive Decision Memorandum
 Governed by United States Code, VHA Directives, and Handbooks:
 38 U.S.C. 7401(1, 3) (Appointments in Veterans Health Administration)
 38 U.S.C. 7405 (Temporary, Full-Time Appointments, Part-Time Appointments, and Without-Compensation Appointments)

VHA Directive 2012-030, Credentialing of Health Care Professionals
 VHA Handbook 1100.17 - National Practitioner Data Bank Reports
 VHA Handbook 1100.18 - Reporting and Responding to State Licensing Boards
 VHA Handbook 1100.19, Credentialing and Privileging
 VA Handbook 5005 - Staffing
 VA Handbook 5007 - Pay Administration

Office of Geriatrics and Extended Care Operations

Overview

Office of Geriatrics and Extended Care (GEC/10NC4) Operations facilitates the delivery of care for Veterans with serious chronic diseases and disabling conditions through a comprehensive spectrum of facility-based (institutional) and home- and community-based care (non- institutional care) programs.

Facility-based Care (Institutional Care Programs)

Functions and Activities

- Manages contract of State Veterans Homes (SVH) to ensure compliance with VA's standards and regulations regarding nursing home care, domiciliary, and/or adult day health care.
- Reviews and responds to SVH issue briefs, surveys report reviews and close outs, and survey appeals.
- Provides oversight for operations of the Community Nursing Home (CNH) program that provides care for Veterans in community nursing homes.
- Provides guidance to VA medical centers to provide adequate monitoring and follow-up services for Veterans in the CNH Program within their local catchment area.
- Supports Community Living Center (CLC) operations to transform the culture of care in VA CLCs to refined communities of Veterans living together as comfortably and independently as possible in a setting reminiscent of the homes they defended with their service.
- Provides clinical and quality oversight through unannounced surveys, standardized action plans, trending data, reports, policies, and issue briefs.

Home- and Community-based Care (Non- institutional Care Programs)

Functions and Activities

- Manages the Home-based Primary Care (HBPC) program, which provides comprehensive, longitudinal primary care by an interdisciplinary team through home visits in urban, rural, highly rural and Native American land. HBPC coordinates care and incorporates nutritional, cultural, mental health, rehabilitative, spiritual and clinical needs of the Veteran through individualized Veteran-centered holistic care plans and ongoing assessments for Veterans.
- Oversees and manages Comprehensive End-of-Life Care services, such as bereavement care, and hospice and palliative services with an interdisciplinary team of health care providers, and creates individualized plan of care to meet medical, social, spiritual, and psychological needs.

- Provides guidance and oversight on the operation of Adult Day Health Care at VA medical centers, which provides therapy with activities, socialization, health services, and caregiver respite in a safe, group setting. Establishes methods for the purchase of these services from Community providers.
- Coordinates Veteran-Directed Services, which provides Veterans and their caregivers with more access, choices, and control over their community-based long-term care services, and Homemaker and Home Health Aide care, which assists Veterans with personal care, chores or other activities of daily living.
- Provides guidance and oversight of respite care services in the home and in other community settings in adherence with the Veterans Millennium Health Care and Benefits Act.
- Coordinates Community Residential Care, which provides health care supervision and personal assistance in a residential care facility to eligible Veterans who are unable to live independently.
- Coordinates Medical Foster Homes (MFH), a form of Community Residential Care that provides health care supervision and personal care assistance in a personal family home to Veterans who meet nursing home level of care need.
- Coordinates Geriatric Evaluation and Management, which provides comprehensive interdisciplinary evaluation and management of Veterans with multiple chronic diseases and disability conditions, through primary or consultative services in outpatient and inpatient settings.
- Coordinates Geriatric Primary Care, which provides medical care, nursing care, therapy, mental health, disease treatment and prevention, health maintenance and education, referral for specialty care, and overall care management for elderly Veterans in an outpatient clinic setting.
- Collaborates with Geriatric Research, Education and Clinical Centers (GRECC) to increase health care providers' basic knowledge of aging, and improve the quality of care through improved models of clinical services, and a wide variety of educational activities targeting VA staff and trainees from the full range of health disciplines.
- Coordinates Alzheimer's and dementia care through a full range of VA health care services depending on Veterans' needs.

Office of Mental Health Operations

Overview

Office of Mental Health Operations (OMHO/10NC5) continuously monitors and supports the implementation of mental health policies and the performance of mental health programs in the VISNs and facilities; and periodically conducts evaluations of mental health services and policies.

Functions and Activities

- Works with VISN and facility leadership to identify areas of anticipated growth and unmet Veteran needs, and assist in implementing programs to meet these demands.

- Monitors mental health clinical services through various dashboard tools through its three Mental Health Program Evaluation Centers and reviews the data quarterly with VISN and facility leadership.
- Provides facility-specific technical assistance and conducts oversight and consultation visits as needed.
- Coordinates with VISN Mental Health Leads and facilities in addressing any action plans for quality improvement.
- Provides technical assistance in the deployment of new mental health services.
- Develops models, guidance, and assistance to decrease variability in existing services.
- Provides oversight and management of the Therapeutic and Supported Employment Services Program and the National Clozapine Coordinating Center.

National Program Office for Sterile Processing

Overview

The National Program Office for Sterile Processing (SPS/10NC6) ensures the safety of Veterans by developing national policy and oversight of all sterile processing and high-level disinfection activities for critical and semi-critical reusable medical equipment.

Functions and Activities

- Program office subject matter experts conduct facility site visits to review and advise on sterile processing activities, and to provide special assistance when failures in sterile processing activities pose potential risks to Veterans.
- Identifies risks to Veterans when sterile processing activities are not performed correctly through analysis of process failures and potential for harm to Veterans. Subject matter experts or health specialists recommend corrective actions to the Facility Director, VISN Director, and VHA leadership.
- Provides guidance and policies for facility and VISN-led inspections of sterile processing activities, collects, and analyzes data to identify trends and address frequently occurring problems across facilities, and recommends corrective actions to the ADUSH/CO.
- Conducts training and continuing education programs to ensure competencies in the sterile processing workforce.
- Develops national policy and guidance for sterile processing activities, including technical specifications, competency assessments, oversight of sterile processing functions at the facility level, and integration with other clinical services.

*Office of Dentistry***Overview**

Office of Dentistry (10NC7) establishes and deploys policy for VA Dental Services to ensure uniform and consistent national procedures for providing oral health care to eligible Veterans.

Functions and Activities

- Fields and maintains the Dental Encounter System, and client-facing Dental Reporting and Analytics System (complementary business intelligence systems) to assess and improve evidence-based and data-driven organizational and individual performance.
- Develops evidence-based clinical quality indicators that ensure eligible Veterans receive a primary care dental provider, regular exams, cleanings, and appropriate fluoride treatments to drive improvement in Veteran oral health.
- Maximizes access to dental care for additional homeless Veterans by continually refining and monitoring distribution of Homeless Veteran Dental Program funds.
- Maintains Central Dental Laboratory services to support the needs of eligible beneficiaries. Services include, but are not limited to, dental crowns, bridges, and removable partial denture frameworks.

Authorities

38 U.S.C. §§1710(c), 1712
 38 CFR 17.160 – 17.166.
 38 U.S.C. §2062
 38 U.S.C. §1720D.
 38 U.S.C. §5313B,
 VHA Directive 1130
 VHA Handbook 1130.01

*Office of Disability and Medical Assessment***Overview**

The Office of Disability and Medical Assessment (DMA/10NC8) provides executive leadership to VHA's disability programs worldwide, including both the traditional Compensation and Pension (C&P) and the Integrated Disability Evaluation System (IDES) programs. These responsibilities include gathering budget estimates, securing and execution of funding, quality performance improvement, contract management, clinician certification and training providing analytics support, and development of national (C&P) policy. DMA works closely with its stakeholders to include VHA, the Veterans Benefits Administration (VBA), the Office of Information and Technology (OIT), the Board of Veterans Appeals (BVA) and the Department of Defense (DoD) to project future requirements necessary to meet the demands for services in response to new initiatives and legislation. DMA works with DoD, VBA, Office of Policy and Planning (OPP), and Health Affairs (HA) to manage and monitor programs to provide disability examinations for Service members, including IDES and Separation Health Assessments (SHA).

Functions and Activities

- Provides medical authority for medical components of the VA C&P disability evaluation and reporting process.
- Develops, implements, and provides education and training for disability evaluation and examination programs.
- Provides expert medical opinions on complex issues upon stakeholders' requests.
- Monitors performance measures of examination report timeliness and quality. These monitors assess performance for timeliness at the national, VISN, and facility levels. Performance for quality is measured at the national and VISN levels.
- Develops near-, short- and long-term strategic plans to support ongoing operations and expansion of DoD/VA initiatives by developing policies, best practices, and extending VA tools and systems to effectively manage IDES.
- Develops examination protocols, standardization and specialized reporting for SHA related disability examinations for utilization by DoD, VBA, and BVA over the broad range of individual pre-discharge type programs.

Authorities

21 U.S.C. § 321
 38 U.S.C. § 73 Subchapters I-IV
 38 U.S.C. §§ 2011-2013
 38 U.S.C. § 2022
 38 U.S.C. § 2031
 38 U.S.C. § 2033
 38 U.S.C. § 2034
 38 U.S.C. § 2044
 38 U.S.C. § 2061
 38 U.S.C. § 2065
 38 U.S.C. § 1710B
 38 U.S.C. § 1712
 38 U.S.C. § 1717
 38 U.S.C. § 1720C
 38 U.S.C. § 1718
 38 U.S.C. § 5103A
 38 U.S.C. § 7109
 42 U.S.C. § 362
 42 U.S.C. § 1437f (o) (19)
 P.L. 111-8, Title II (123 Stat. 961)
 P.L. 112-154 § 304
 P.L. 99-166, Title II
 P.L. 106-117
 38 CFR 3.159
 38 CFR 3.326
 38 CFR 3.655

38 CFR Part 4
 38 CFR 17.160-17.166
 45 CFR 164.512
 VHA Directive 1046
 VHA Directive 1602
 VHA Directive 1603
 VHA Directive 2008-071
 VHA Directive 2010-012
 VHA Directive 2010-024
 VHA Directive 2010-027
 VHA Directive 2011-018
 VHA Directive 2012-021
 VHA Directive 2012-025
 VHA Directive 2012-036
 VHA Directive 2013-002
 VHA Handbook 1601B.05
 VHA Handbook 1907.1
 Vet. Aff. Op. Gen. Couns. Prec. 4–91, VAOPGCPREC 4–91
 VHA Executive Decision Memo of March 7, 2011, “Activation of the Office of Disability and Medical Assessment”

Spinal Cord Injury and Disorders System of Care

Overview

Spinal Cord Injury and Disorders (SCI/D/) System of Care (10NC9) is the largest single network of Spinal Cord Injury and Disorders care nationwide. Utilizing a “hub and spokes” structure and located in various parts of the country, this healthcare system promotes the health, independence, quality of life, and productivity of Veterans with SCI/D from initial injury or illness through their lifespan.

Functions and Activities

- Provides an integrated and coordinated continuum of services that addresses the needs of Veterans with SCI/D from initial injury or illness through their lifespan.
- Provides comprehensive health care, including primary care, acute rehabilitation, acute medical and surgical care; ventilator management and weaning; annual health promotion and wellness evaluations; early detection and management of secondary and co-morbid conditions; management and treatment of chronic pain; functional assessments; interventions to optimize independence, economic self-sufficiency, social role participation, and quality of life; home care; extended and long-term care; respite care; and end-of-life care.
- Coordinates education, training, and resources for Veterans, family members, primary and specialty care providers, policy makers, and other stakeholders.
- Supports research activities that advance care and support improved outcomes for Veterans with SCI/D.
- Provides specialized care at VA medical facilities for Service members through a long-standing Memorandum of Agreement between VA and DoD.

- Maintains accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission for SCI/D centers.

Authorities

VHA Directive 1176
 VHA Handbook 1176.01
 VHA Directive 2008-085
 38 U.S.C. § 1706
 38 U.S.C. § 1717

Access and Clinic Administration Program

Overview

Access and Clinic Administration (10NC10) examines all parts of integrated delivery systems to identify opportunities to reduce variation, remove waste, and manage constraints.

Functions and Activities

- Provides access, scheduling, and consult policy direction for VHA.
- Collaborates with other VACO program offices to improve telephone access to care for Veterans.
- Leads and facilitates improvements to patient access to health care through education, training, consultation and subject matter expertise.
- Responsible for development of data tools in collaboration with other program offices for use in data analysis and oversight of VHA performance for access, scheduling and consult metrics.

VHA Patient-Centered Care and Cultural Transformation

Overview

The Office of Patient-Centered Care and Cultural Transformation (OPCC&CT/10NE) leads the transformation of health care from a primarily reactive, disease focused model to a personalized, proactive, patient-centered care. This model prioritizes the Veteran and their values, and partners with them to create a personalized strategy to optimize health, healing, and well-being that is based on relationships built on trust and committed to positive results over the Veteran's lifetime.

Patient-centered care "practice" begins with the Veterans' vision of health and their goals. It links Veterans' personalized health plans to what matters to them in their lives, and it supports them in acquiring the skills and resources they need to succeed in making sustainable changes in their health and life. The "experience" establishes continuous healing relationships and provides optimal healing environments. The ultimate results are better health outcomes, improved quality of care, greater patient and provider satisfaction, and greater cost effectiveness.

Functions and Activities

- OPCC&CT partners with VISNs, medical centers, and program offices to develop strategies and plans that implement patient-centered care nationally.

- Partners with nine Centers of Innovation in the field as well as VISNs, VAMCs, Vet Centers, and other environments across the continuum of care to pilot new practices, and integrate and align current programs with the elements of patient-centered care.
- Leads national implementation of complementary and integrative health through the Integrative Health Coordinating Center (IHCC).
- Co-chairs the National Leadership Veteran Experience Committee, which reports to the National Leadership Council (NLC), and takes a leadership role in advising the NLC and Under Secretary for Health on a wide range of issues related to the enhancement of Veterans' experience of care in VHA.
- Develops education and training for staff and Veterans as part of the VHA-integrated curriculum and strives to embed elements of patient-centered care in all forms of education. Provides personalized health planning and health coaching training as integral components of the planned curriculum related to the practice of health care.
- Assists Veterans in identifying areas for skill development to successfully change behaviors and achieve personal health goals using a Health and Well-Being tool.
- Cultivates innovation, analyzes outcomes, and deploys best practices and innovations nationally.
- Develops partnerships with measurement and research program offices to effectively evaluate outcomes.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV

Office of Network Support and Veterans Integrated Service Networks

Overview

The Office of Network Support serves as liaison between VHA Central Office and 19 VISNs, providing guidance and consultation to develop recommendations for VHA senior leadership on operational matters and sensitive issues impacting VHA facilities. Three teams of Health System Specialist teams liaise among the Facility, VISN, and VHA Central Office. A team of three management analysts track and run daily data reports used by the Deputy Secretary of the VA to monitor Veterans' access to care, the Choice Act, other Non-VA care, and care quality.

Functions and Activities

- Provides 24 hour critical reporting to VA Senior Leaders.
- Manages the VHA issue brief tracker.
- Compiles data for the congressionally mandated report for sexual assault prevention.

Deputy Under Secretary for Health for Organizational Excellence

Overview

The Office of the Deputy Under Secretary for Health for Organizational Excellence (DUSHOE) brings together the vital pieces of the Veterans Health Administration that focus on: assessing and improving quality and safety; providing the field and leadership with analytics and tools to assess how VHA is performing as an organization; building and supporting the capability in the field to assess risks and achieve and sustain high performance; promoting health equity; and addressing issues related to public trust and integrity. By integrating multiple VHA program offices under a collaborative directorate, the DUSHOE is positioned to improve VHA organizational efficiency and effectiveness.

Functions and Activities

- Plans, directs, coordinates, and evaluates programmatic initiatives aimed at ensuring high quality healthcare for Veterans; improved efficiency in VHA clinical and business operations; an environment of continuous learning and improvement; and promotion of a just culture.
- Provides leadership in establishing a stronger foundation for consistency, high performance, and high reliability across all VHA, in accordance with applicable laws, regulations, and standards.
- Partners externally with government, academia, private sector, and non-profits to develop and review national policy associated with our top priorities.
- Partners internally, with VHACO leadership and the field to introduce, implement, and disseminate new learning and best practices.
- Aligns the ADUSH for QSV and the ADUSH for Integrity under a single management authority to effective integration for inspection and quality.
- Collaborates with internal counterparts who manage operations, policy and services to assure seamless approaches to the strategic plan and priorities for VHACO and the field.
- Oversees the development of training and education strategies that will develop the core competencies needed to affect a futuristic quality agenda within, and among an engaged workforce.
- Provides broad oversight of and accountability for preparation of the required budgetary and appropriation requests to support successful implementation of quality improvement strategies and related priorities for the Veteran population.

Authorities

P.L. 114-41.

Chief Improvement Office

Overview

This Chief Improvement Office (10EA) is new to VHA and 10E, and will focus on building and supporting capabilities in the field to improve all aspects of care and sustain those improvements. The DUSHOE is

in the process of standing up the program, assigning a director, establishing priorities and mapping a staffing plan by leveraging existing resources.

Office of Health Equity

Overview

The Office of Health Equity (OHE/10EB) strengthens and broadens the ability of VHA leadership to address health inequalities and reduce health disparities through pursuit of health equity in all policies, operations, oversight, and research. Working to promote health equity through policies, education/communication, data analysis and improvement of health care outcomes, OHE positively impacts the health and health care of vulnerable sub-populations within VHA.

Functions and Activities

- OHE impacts health and health care equity for Veterans by working to remove barriers preventing appropriate individualized health care and outcomes for all by cultivating commitment of top VA leadership and senior leaders throughout the organization for successful implementation of the VHA Health Equity Action Plan.
- Increases awareness of internal and external stakeholders of the significance of health inequalities and disparities, their impact, and the actions necessary within VHA and among stakeholders to improve health care and health outcomes for vulnerable Veteran populations.
- Improves health and health care outcomes for Veteran sub-populations experiencing health disparities by assessing Veteran enrollment in benefits and health care programs, tracking sub-populations' market penetration over time, analyzing reasons for any identified disparities and incorporating the consideration of health inequality and disparities in every strategic resource and clinical decision (e.g., using the framework of integrated ethics).
- Works with other VHA offices to identify and establish outcome metrics for awareness of eligibility, access to benefits, health care delivery, and patient satisfaction consistent with those used in Healthy People 2020 and the annual Health Disparities Report published by the Department of Health and Human Services.
- Improves cultural and linguistic competency and the diversity of the VA workforce involved in advancing the health and well-being of Veterans by promoting understanding of the link between workforce diversity and achievement of equity in health care and outcomes, and promoting interactive cultural competency training that addresses bias, behaviors, attitudes, and integrates recognition of culture and social determinants of health into the delivery of health care services.
- Improves the availability, coordination, and utilization of data and evaluation of outcomes, as well as the diffusion of research to track progress toward the achievement of health equity.
- Monitors, coordinates, and provides assistance and guidance to further research and improvement efforts, and to translate research and quality improvement findings into operation plans, clinical treatment, education, and related services.

- Partners with Analytics and Business Intelligence and other program offices to assess access and quality of care differences associated with individual characteristics, including but not limited to sex, race, ethnicity, geography, age and sexual orientation and develop approaches to addressing inequitable health care delivery, health outcomes or satisfaction with care.

Authorities

38 U.S.C. 73 and applicable Subchapters I-IV

Office of the Assistant Deputy Under Secretary for Health for Integrity

Overview

New to VHA as part of the 2016 reorganization, the Office of the Assistant Deputy Under Secretary for Health for Integrity (ADUSH/I/10E1) synthesizes information from internal and external oversight activities to promote a strong ethical and just culture that builds trust and confidence in Veterans health care.

Functions and Activities

- Achieve continuous improvement in health care system performance by integrating VHACO's oversight, compliance, and accountability functions.
- Serve as VHA's principal liaison to external oversight bodies (GAO, OIG, and OSC).
- Conduct internal oversight activities (investigations, audits, risk assessment, and business compliance) in accordance with VHA policy and industry standards.
- Proactively identify system vulnerabilities and manage risk across clinical, administrative, business, and financial domains.
- Demonstrate VHA commitment to address high risk areas identified by GAO.
- Serve as primary VHA resource for addressing complex ethical issues related to clinical ethics, organizational ethics, and research ethics.

Office of Compliance and Business Integrity

Overview

The Office of Compliance and Business Integrity (CBI/10E1A) provides guidance to VHA Leadership on healthcare business -related compliance issues. CBI ensures that, in alignment with VA standards and healthcare industry guidance, protocols are in place to prevent, detect, and oversee correction of noncompliant activity, thereby preserving Veterans trust in the care they receive from VHA.

Functions and Activities

- Serves as principal resource of CBI program standards in alignment with industry standards for an effective compliance program.
- Provides independent assurance of reliability and precision of business operations, which enhance and strengthen a culture of accountability, integrity, and compliance in service of Veterans.

- Provides internal oversight of revenue operations to comply with applicable laws, regulations and standards.
- Develops a standardized approach for evaluating business transactional precision and performance for revenue cycle and purchased care activities.
- Develops tools and systems to identify and oversee mitigation of enterprise-wide healthcare business-related risks (i.e., education and curriculum development specific to risk life cycle and risk management).
- Provides targeted guidance, education and training to field CBI Officers to support local CBI Program initiatives in alignment with core priorities and needs.
- Conducts site visits to review compliance programs at all levels on the implementation and improvement of compliance program elements, as well as evaluate the effectiveness of compliance programs.

Authorities

VHA Directive 1030, Compliance and Business Integrity Oversight Program, February 26, 2016.

HHS OIG Compliance Program Guidance.

United States Sentencing Commission Sentencing Guidelines (USSC).

Executive Order 13520, Reducing Improper Payments and Eliminating Waste in Federal Programs.

Improper Payments Elimination and Recovery Act of 2010,.

Improper Payments Information Act of 2002

Office of Management and Budget (OMB), Circular A-123, Management's Responsibility for Internal Controls.

OMB, Circular A-123, Appendix C, Requirements for Effective Measurement and Remediation of Improper Payments. Parts I and II (4/14/11)

<http://www.whitehouse.gov/sites/default/files/omb/memoranda/2011/m11-16.pdf> and Part III, Issuance of Revised Parts I and II to Appendix C of OMB Circular A-123 "

http://www.whitehouse.gov/sites/default/files/omb/assets/memoranda_2010/m10-13.pdf, Issuance of Part III to OMB Circular A-123, Appendix C

OMB Executive Memorandum M-12-11, Reducing Improper Payments through the "Do Not Pay List".

http://www.whitehouse.gov/sites/default/files/omb/memoranda/2012/m-12-11_1.pdf

5 CFR 2635 – Standards of Ethical Conduct for Employees of the Executive Branch.

VA Handbook 5021/15, Part I, Employee/Management Relations, Appendix A, Table of Penalties for Title 5 and Title 38 Employees

Office of the Medical Inspector

Overview

The Office of the Medical Inspector (OMI/10E1B) is responsible for assessing the quality of VA health care through investigations of VA facilities nation-wide, reporting directly to the Assistant Deputy Under Secretary for Health for Integrity (ADUSHI), Deputy Under Secretary for Health, Organizational Excellence. OMI conducts three types of investigations: employee whistleblower allegations referred to VA by the Office of Special Counsel (OSC); individual Veteran complaints referred by the Office of the Inspector General (OIG), Congress, or other stakeholders; and site-specific internal reviews directed by the Under Secretary for Health (USH).

Functions and Activities

- At the direction of the Office of the Secretary or the Under Secretary for Health (USH), OMI conducts health care investigations, documenting findings and producing reports with recommendations for quality improvements.
- Assembles and leads VA teams of clinical investigators, subject matter experts, and human resource specialists.
- Conducts site visits, taking testimony from medical center leadership and relevant staff.
- Briefs VHA leadership on preliminary site visit findings.
- Documents findings, conclusions, and recommendations in comprehensive reports.
- Circulates draft reports to VA and VHA offices for review and comment, obtaining concurrences from key offices, prior to submitting final reports to the USH for approval.
- Monitors implementation of VA medical center action plans in conjunction with 10N, and of VHA Program Office action plans with 10E.
- Prepares supplemental reports and email clarifications as requested.
- Promotes evidence-based best practices and cross-fertilization of ideas between VHA Central Office and field facilities to improve patient care outcomes.
- Identifies system risks and vulnerabilities across the VA health care system by observing patterns and trends among the findings of investigative reports.

Authorities

P.L. 100-322 § 201

VHA Directive 2011-002: Office of the Medical Inspector Reports

VHA Directive 2011-031: Cooperation with the Office of the Medical Inspector

Internal Audits and Risk Assessment

Overview

New to VHA as part of the 2016 reorganization, the Office of Internal Audits and Risk Assessment (10E1C) is in the process of being developed within the auspices of the Office of the ADUSH for Integrity. The office will proactively identify system vulnerabilities and manage risk across clinical, administrative, business, and financial domains.

Management Review Service

Overview

The ADUSH for Integrity oversees the Management Review Service (MRS/10E1D), VHA's primary liaison with OIG and GAO for national reviews, audits, and inspections.

Functions and Activities

- Partners VHA subject matter experts with OIG and GAO teams to develop the focus, scope, and methodology of national reviews, national audits, or national inspections.
- Ensures VHA program offices comply with standards or protocols for OIG and GAO national reviews and audits.
- Facilitates appropriate and timely responses to OIG or GAO draft reports, recommendations to the Under Secretary for Health, and data requests related to national reviews or audits.
- Notifies VHA leadership of GAO and OIG findings that require new or different VHA standards.
- Ensures VHA program offices are implementing processes toward resolution of GAO and OIG recommendations, or facilitates negotiations for reasonable resolutions.

Authorities

[OMB Circular A-50](#)

National Center for Ethics in Health Care

Overview

The National Center for Ethics in Health Care (NCEHC/10E1E) is the primary VHA resource for addressing the complex ethical issues that arise in health care, including issues relating to clinical ethics, organizational ethics, and research ethics. NCEHC works collaboratively with program offices and field stakeholders to make recommendations to promote strong ethics and professionalism standards. NCEHC aims to continuously improve VHA's ethics-related decisions, actions, systems, processes, environment, and culture by establishing standards and providing analysis, information, education, advice, and support to VHA senior leadership, field facilities and program offices.

Functions and Activities

- Establishes updates, interprets, and clarifies standards for ethical health care practice by providing policies, authoritative reports, and other similar guidance, to include publishing information for Veterans to help them understand the ethics standards they encounter in VHA.
- Creates and promulgates a model for health care ethics programs called IntegratedEthics®; establishes IntegratedEthics® program standards and annual performance targets and roles, responsibilities and training requirements for IntegratedEthics® staff.
- Serves as a resource for information, advice, and support related to ethics in health care within VHA to include representing VHA on matters relating to health care ethics in communications with media, congress, and the White House.
- Supports efforts to increase ethical health care practices by conducting and facilitating systematic evaluation of ethics programs and practices in VHA; develops measures to assess the quality of ethics consultation practices and to monitor the implementation of specific ethics policy standards.

Authorities

38 U.S.C. § 7301(b)

38 U.S.C. § 7306
 38 U.S.C. § 7331
 38 CFR § 17.32
 42 U.S.C. § 1395cc (f)
 VHA Directive 1004
 VHA Handbook 1004.01
 VHA Handbook 1004.02
 VHA Handbook 1004.3
 VHA Handbook 1004.04
 VHA Handbook 1004.05
 VHA Handbook 1004.06
 VHA Handbook 1004.07
 VHA Handbook 1004.08
 VHA Directive 1005

Office of the Assistant Deputy Under Secretary for Health for Quality, Safety and Value

Overview

The Office of the Assistant Deputy Under Secretary (ADUSH) for Health for Quality, Safety and Value (QSV/10E2) is committed to enhancing VHA's ability to be the most trusted choice for high quality, safe and reliable health care by ensuring outstanding population health, a seamless patient experience, and the lowest expenditure of resources. The office allows VHA to provide the best health care value to Veterans by enabling innovative, enterprise-wide approaches to compliance, risk awareness and continuous improvement.

Functions and Activities

- QSV anticipates and manages risks by ensuring VHA clinical and business processes are highly reliable, educating the workforce, and encouraging highly effective collaborative teams dedicated to improvement.
- QSV conducts a variety of functions, through its sub offices listed below, to foster a culture that acts with integrity to achieve accountability while remaining mindful, proactively risk aware, and predictable in delivery systems.

Analytics and Business Intelligence

Overview

Analytics and Business Intelligence (ABI)/10E2A provides timely and reliable analytic and business intelligence data and products to support and improve clinical and operational programs at all levels of the VHA health care delivery system. ABI's sophisticated analytic and business intelligence solutions facilitate evidence-based decisions for Veterans and their families, patient populations, clinicians and those managing health care delivery systems.

Functions and Activities

- Provides oversight, access, analysis and reporting of data to internal VA organizations and program offices for the purpose of health care delivery/clinical oversight, including dashboards,

cubes and reports for primary and specialty care (e.g., homelessness, rural health, OEF/OIF/OND, Women Veterans, VA/DoD sharing) and nursing.

- Supports the External Peer Review Program (EPRP) and Survey of Health Experiences of Patients (SHEP), including developing measures to track clinical and other outcomes based on the philosophies of evidence-based practice, where multidisciplinary national experts within VHA incorporate best evidence derived from research into clinical practice guidelines for VHA's highest volume, highest risk conditions, and measurement and accountability.
- Clinical Assessment Reporting and Tracking (CART): Collects data at the point of care on every coronary procedure performed in all VA Cardiac Catheterization Laboratories and uses the data to optimize quality and safety.
- Predictive Analytics: Uses context sensitive, relevant information to identify unrecognized relationships and develop sophisticated analytic models to predict important clinical outcomes.
- Strategic Analytics for Improvement and Learning (SAIL): Web-based, balanced scorecard model developed to measure, evaluate and benchmark quality and efficiency at medical centers on a quarterly basis. SAIL is designed to offer high-level views of health care quality and efficiency, enabling executives and managers to examine a wide breadth of existing VA measures.
- Specialty Productivity - Access Report Quadrant tool (SPARQ): Web-based tool that integrates specialty physician productivity data and measures of access to specialty care into an algorithm to guide staffing decisions of specialty care physicians.
- Scheduling Accuracy Dashboard: Trigger system derived from statistical process charts to monitor the integrity of wait time data and compliance with scheduling practice.

Quality Standards and Programs

Overview

Quality Standards and Programs (10E2B) promote the integration and alignment of health care regulatory and governance strategies. Key accreditation, mission readiness, and ISO-9001 emphasis functions work together to promote further integration with clinical and business compliance programs and to better direct consultative and education resources to high-risk areas while avoiding needless survey burden on facility operations.

Functions and Activities

- QSP promotes the integration and alignment of health care regulatory and governance strategies. Key accreditation, mission readiness, and ISO 9001 emphasis functions work together to promote further integration with clinical and business compliance programs to better direct consultative and education resources to high-risk areas while avoiding needless survey burden on facility operations.

*Division of External Accreditation Services and Programs***Overview**

The External Accreditation Program is responsible for managing accreditation vendors within VHA that provide regulatory accreditation of health care facilities, Community Based Outpatient Clinics (CBOC) and Consolidated Mail-Out Pharmacies (CMOP). The accreditation vendors are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) and vendors for consultation and education on survey readiness within VHA.

Functions and Activities

- Acts as the national liaison to accreditation vendors identified for External Accreditation Services to VHA facilities.
- Responsible for budgeting for all accreditation services that are provided by external accreditation vendors.
- Provides consultation services to VACO Programs, VISNs and VHA field facilities related to accreditation process, education and ongoing survey readiness.
- Monitors accreditation status within VHA by collecting, trending and assessing data from accreditation surveys. Provides VHA Leadership, Networks, VISNs and facilities with ongoing trends related to regulatory standards compliance. Identifies national opportunities for improvement related to quality, safety and efficiency as they relate to ongoing accreditation survey findings.
- Develops and provides educational webinars, national conference calls and conferences on accreditation standards compliance for The Joint Commission and CARF.

Authorities

VHA Handbook 1170.01 Accreditation of Veterans health Administration Rehabilitation Programs

VHA Handbook 11000.16 Accreditation of Medical Facilities and Ambulatory Programs

*ISO Consultation Division***Overview**

The ISO Consultation Division (ICD) infuses the standards-based discipline of ISO-9001 quality management into the health care delivery processes and programs. This, in turn, promotes sustained reliability and excellence in daily practices and service for our Veterans.

Functions and Activities

- Supports the creation of effective, repeatable, and highly-reliable, processes for use throughout the continuum of Veteran health care.
- Implements ISO 9001, the global benchmark for quality management, in all facilities, beginning with Sterile Processing Services (SPS).
- Proactively implements consistent quality management systems that become benchmarks for the public and private sectors for continual improvement and elevation of the standard of Veteran-centric care.

*The Utilization and Efficiency Management Program***Overview**

The Utilization and Efficiency Management Program (UM) actively manages quality and resource utilization. The program provides a series of initiatives and automated tools to ensure Veterans receive the right care at the right time, in the right place, for the right clinical reason.

Functions and Activities

- Ensures a standardized process, proper use of evidence-based utilization criteria and entry of utilization findings into the National Utilization Management Integration (NUMI) database.
- Ensures that the 600+ field-based UM professionals are properly educated and trained to interpret evidence-based criteria, perform utilization reviews and use the data from these reviews to improve efficiency.
- Develops Consolidated Utilization Management metrics through clinical review and consultation using industry standard evidence to assure the right care at the right time, in the right setting, for the right reason.
- Reviews Utilization Management data and other utilization and efficiency reports, and through consultation and education, assists facilities to evaluate and improve clinical efficiency.
- In collaboration with oversight committees, determines and implements additional utilization modalities, and prepares UM workforce to apply criteria, collect utilization data, and improve efficiency through the health care continuum.

*Health Systems Innovation Planning and Coordination***Overview**

Health Systems Innovation Planning and Coordination (HSIPC) works in collaboration with clinical partners to plan and execute IT/IM strategies in support of healthcare quality and continuous improvement.

Functions and Activities

- Conducts business analyses to identify, analyze, and document business processes for healthcare operations, and assists with planning and task coordination related to QSV-sponsored software development and sustainment.
- Identifies opportunities to add value, reliability, and efficiency to healthcare operations through system integration and process refinement.
- Informs strategic planning and process execution in real time by conducting data analyses, synthesizing business intelligence and delivering business intelligence products to meet customer requirements.
- Represents the Office of Quality, Safety and Value on the VHA IT Committee and its Health Informatics Strategic Plan subcommittee.

*Evidence-Based Practice Program***Overview**

Evidence-Based Program develops evidence based clinical practice guidelines and disseminates evidence-based standards into the delivery process to improve Veteran care by reducing overuse, misuse, and underuse of evidence-based practice, and systematizing “best known clinical practices.” .

Functions and Activities

- Works with the Department of Defense (DoD) to develop evidence-based clinical practice guidelines to be used within VA and DoD. VA/DoD guideline-development work is conducted under the auspices of VA/DoD Evidence-Based Practice Working Group (EBPWG), which is chartered by VA/DoD Health Executive Committee (HEC).
- Identifies and assesses opportunities to improve the adoption of evidence-based clinical practices through the coordination and sharing of health-related services and resources between the Departments.
- Champions the integration of evidence-based clinical practice into current developing information systems.
- Fosters integration of evidence-based practice into VA/DoD initiatives related to health promotion, disease prevention, and wellness initiatives.
- Assesses the effectiveness of implementation and makes recommendations to maximize performance improvement.

*High Reliability Systems & Consultation***Overview**

The High Reliability Systems and Consultation Program (10E2C) has as its primary objective the development of integrated, organization-wide capability to continuously improve processes toward the goal of High Reliability healthcare delivery across the continuum, including focuses on predictability, prevention of harm, and standardization of best and promising practices.

Functions and Activities

- To propose, develop, and facilitate deployment of innovative solutions to challenges within VHA healthcare delivery.

*Systems Redesign and Improvement Program***Overview**

The Systems Redesign and Improvement program supports the development of VHA improvement capability to examine all parts of the VHA integrated delivery system with the overarching goal of identifying opportunities to reduce variation, remove waste, and manage constraints.

Functions and Activities

- Leads and facilitates the implementation of high reliability systems at VHA facilities and within VHA networks through investment in building improvement capability across a robust systems improvement community of practice.
- Leads and facilitates improvements impacting patient flow and access to health care across the healthcare continuum through sponsorship of VHA Flow Improvement X-Cellence (FIX) program initiatives.
- Trains and supports teams at local, regional, and national levels to develop competency and apply improvement methods/tools to include, but not be limited to, Lean, Lean Six Sigma, and the VA-TAMMCS (Vision, Analysis, Team, Aim, Map, Measure, Change, Sustain) framework, to continuously improve delivery systems toward efficiency and optimization.
- Develops and facilitates national improvement initiatives in partnership with VHA program offices and Field-based experts to support VAMC improvement work with a direct impact on Veteran-centered care.
- Supports inpatient access to care, operations, and optimization of inpatient flow through national patient flow coordination role focused on inter-facility/inter-VISN transfer coordination and Bed Management Solution (BMS) bed/patient tracking application business ownership.
- Leads coordination of the Integrated Flow Optimization (IFO) strategy centered upon integration of key flow informatics applications to include Bed Management Solution (BMS), Emergency Department Integration Software (EDIS), and National Utilization Management Information (NUMI) system, along with dashboards and tools such as the Integrated Flow Management Tool (IFMT).

Veteran Engineering Resource Centers

Overview

The Veteran Engineering Resource Centers (VERC) systemically apply the concepts of industrial and systems engineering in health care to derive safe, efficient solutions and optimized platforms of care delivery. The VERC program is co-located and managed via four individual sponsoring facilities. These facilities include: the Midwest Mountain VERC (Center for Health Engineering) - Albuquerque VAMC; the VA-CASE VERC – Indianapolis VAMC; the New England VERC – Boston VAMC; and the VA Pittsburgh VERC – Pittsburgh VAMC.

Functions and Activities

- Leverages engineering analysis and tools to understand the scope and nature of current deficits and bottlenecks.
- Designs and develops engineering solutions to identified clinical and operational systems issues and priorities.
- Teaches engineering principles to health care professionals and health care principles to engineering professionals.

*Health Care Value***Overview**

The Healthcare Value Work stream (10E2D) partners with other QSV Office teams, program offices, VISNs and VAMCs to strengthen healthcare value. Improving healthcare value requires commitment by the entire organization. This Work stream is only one part of the many efforts across VHA that promote value-driven care for Veterans. Our work enhances value through a collective focus on improving population health, Veteran experience of care, and waste reduction.

Functions and Activities

- Fosters internal and external partnerships to promote improved health care value, including participation in national campaigns to enhance value-based delivery for the Veteran populations that we serve.
- Prioritizes, endorses, and supports organizational initiatives that strengthen value-driven care through population health, better experience of care, and efficient health care delivery.
- Fosters collaborative work with research, clinical programs, and analytic partners to increase enterprise value (better health, better care, efficiency).
- Supports education and training content for the work force that address quality, safety, high-reliability concepts, and principles.
- Facilitates strategic communication of quality, safety, and high-reliability policies, evidence, research, and best practices as they relate to enhanced healthcare value.

*Product Effectiveness Program***Overview**

The Product Effectiveness (PE) Program performs independent health care measurement assessments and analysis on health care solutions and process improvements from a business value perspective to ensure these investments are effective and valuable to the organization and all of its stakeholders, including Veterans.

Functions and Activities

- Delivers evidence-based information for management decision support.
- Strongly supports and validates investment decisions, justifications, and accountability for VHA programs.
- Captures, analyzes, and translates data into valuable and actionable information for VHA stakeholders.
- Provides objective analysis to support reducing variation and uncertainty in processes and technology across VHA.
- Optimizes productivity and continuous process improvements through independent performance measurement and assessment services.

- Provides VHA leadership with direct customer input from the field.

Safety & Risk Awareness

Overview

Safety and Risk Awareness (10E2E) works to create a highly reliable organization through a just culture, engaged leadership, high functioning clinical teams with the best staff, improvement of the environment of care, and consideration of emerging and current organizational risks.

National Center for Patient Safety

Overview

The National Center for Patient Safety (NCPS), located in Ann Arbor, Michigan, ensures patient care is safe, preventable harm is reduced, and safety risks are eliminated.

Functions and Activities

- Develops programs and initiatives focused on a systems approach to problem solving, based on prevention, not punishment.
- Develops patient safety products, such as toolkits, checklists, alerts, advisories, and cognitive aides.
- Designs and implements VHA-wide patient safety initiatives and identifies potential practices that could cause harm to patients as a result of their care.
- Develops VHA priorities in patient safety by supporting root cause analysis efforts VHA-wide, reviewing the reported adverse events and close calls, and providing local or national guidance based on the results, as appropriate.
- Leads efforts to utilize the most current research to create a culture of safety that rises above the “name and blame” culture of the past, and is focused on improving or replacing faulty clinical processes that can cause harm to patients, regardless of the caregiver involved.

Medical Staff Affairs

Overview

Medical Staff Affairs (Credentialing and Privileging) oversees and manages the Credentialing and Privileging process which includes collecting relevant data and information to appoint, reappoint, and privilege health care providers, and assure that qualified health care professionals are providing the appropriate care, in the appropriate setting, based upon the scope of their respective privileges.

Functions and Activities

- Supports a culture of safe, competent care by assuring the recruitment and appropriate credentialing of qualified, appropriately licensed health care providers.
- Assists VHA and medical center leadership in meeting the provider competency and oversight of health care delivery to ensure that safe, high quality, reliable care.

- Guides VHA medical center leadership through medical staff processes from recruitment to termination and reporting.

Enterprise Risk Management

Overview

Enterprise Risk Management (ERM) protects the VHA from risks that could interfere with the organization's objectives and goals and mitigate risk where it is unavoidable. ERM in QSV adopts standard risk management processes, but applies them throughout the organization and for all issues, not just liability or loss events and utilizes an alternative lens that examines multiple forms of uncertainty as they affect key objectives for the organization. Thus, the value proposition of ERM within the VHA is that it contributes to:

Functions and Activities

- Sustainability of safe, quality care.
- An integrated, forward-looking, and process-oriented approach.
- Management of key operational risks (not just clinical risks or financial risks) with the long range intent of maximizing value for stakeholders through management of both positive and negative risk potential.

Clinical Risk Management Program

Overview

Clinical Risk Management Program manages an integrated set of activities to systematically identify, evaluate, reduce and/or eliminate, and monitor the occurrence of adverse events and situations arising from operational activities and environmental conditions.

Within the VA, this process frequently involves collaboration with other disciplines such as Patient Safety and Quality Management. The Clinical Risk Management Program ensures that adverse risk events are appropriately addressed at the organizational and provider level to promote learning and encourage a just culture in which staff members have the psychological safety to express quality of care concerns. The quality improvement platforms aligned within VHA QSV Risk Management are but one component of an integrated enterprise risk management program.

Risk management professionals in VHA are facilitators of change, proactively seeking opportunities to support the goal of improved patient care. Review and analysis of VHA-wide data related to facility-level peer review for quality management activities; external audits of peer review for data validation and identification of performance improvement opportunities; and disclosure of adverse events to patients.

Functions and Activities

- Management of activity requirements related to administrative processing of tort claims.
- Assists in the multi-disciplinary VACO program coordination of disclosure of adverse events process for institutional and large scale disclosure.
- Management of the internal peer review for quality management program and the external peer for quality management audit program.

- Develops and leads training programs for clinical Risk Managers to enhance understanding of risk mitigation strategies.
- Provides analysis for the peer review for quality management, institutional disclosure, and tort claim data to support risk assessment and identify opportunities for improvement.

Office of Medical-Legal Affairs

Overview

Office of Medical-Legal Affairs (OMLA) was established to facilitate VHA's support of the Health Care Quality Improvement Act of 1986, which established an HHS system to track practitioners on whose behalf a malpractice claim has been paid.

Functions and Activities

- Coordinates and convenes panels to review all paid VHA tort claims for determining whether the standard of care was rendered.
- Identifies licensed practitioners for reporting to the National Practitioner Data Bank (NPDB).
- At the request of Regional Counsels, provides assignment of needed pre-settlement Medical Advisory Opinions (MAOs) to a Facility outside the VISN where the episode of care occurred. This is centralized through OMLA as a means to ensure equal participation by the VISNs in the required provision of MAOs.
- Leverages paid tort claim information to help inform quality of care and patient safety initiatives.

Public Health Surveillance and Research

Overview

The Public Health Surveillance and Research (PHSR) program office aligns with QSV's mission to enhance the quality, safety, reliability, and value of VHA's clinical systems. PHSR provides VA/VHA leadership and other stakeholders' critical public health surveillance and investigative analyses associated with Veterans care.

Functions and Activities

- Conduct continuous and ongoing VHA system-wide public health surveillance, thereby serving as the early warning system to VHA of impending public health emergencies.
- Promote and support public health surveillance and reporting by VHA facilities through development and dissemination of our online Public Health Reporting Toolkit, and by maintaining close ties with local, state and federal agencies, including the Centers for Disease Control and Prevention (CDC).
- Conduct epidemiological investigations and lookbacks (lookbacks are an organized process for identifying patients and/or staff with exposure to potential risk).
- Operate the Public Health Reference Laboratory which, as VA's primary reference microbiology laboratory, enables VA to rapidly conduct specialized and/or high volume lab diagnostic tests

with little lead time notice in response to clinical care needs, public health investigation and/or health emergencies.

- Provide expert opinion and review on policies generated inside and outside VA; .
- Provide subject matter expertise and scientific research on a wide variety of public health issues and develop products to inform and instruct VA staff on public health policies and procedures.

Deputy Under Secretary for Health for Community Care

Overview

The Office of the Deputy Under Secretary for Community Care (OCC) serves Veterans by collaborating with colleagues and stakeholders as subject matter experts to provide excellence in health care operations and administration. OCC leads VA in advancing business practices that support patient care and delivery of health benefits and provides executive program support to the Under Secretary for Health on a wide range of health benefit administration programs, activities, development of administrative processes, policy, regulations, and directives associated with the delivery of VA health benefit programs.

OCC manages two business lines: Revenue Operations and Purchased Care. Headquartered in Washington, DC, OCC has field offices in Atlanta, Georgia; Topeka, Kansas; Denver, Colorado; Lebanon, Pennsylvania; Las Vegas, Nevada; Leavenworth, Kansas; Asheville, North Carolina; Middleton, Wisconsin; Smyrna, Tennessee; and Orlando, Florida.

Functions and Activities

- OCC leads the transformation of VHA business practices and health benefits policy to support the delivery of quality health care.
- Improves and implements consistent business practices that become benchmarks for the public and private sectors.
- Delivers timely, accurate, and accessible health benefits.
- Delivers accurate, responsive, and respectful customer service.
- Cultivates a dedicated workforce of highly skilled employees who understand, believe in, and take pride in VA's mission.

Workforce Management

Overview

OCC Workforce Management (WFM) supports the delivery of VA Office of Community Care programs through human resources management, employee and leadership development, and related consultative services. Workforce Management is aligned under the VA Office of Community Care and supports managers and employees in OCC's headquarters, Revenue Operations and Purchased Care business lines. Workforce Management also provides workforce support services to field-based entities of VHA's Pharmacy Benefits Management, Member Services and Office of Finance organizations.

Workforce Management staff work primarily from Topeka, Kansas with HR liaisons staffed at all OCC regional locations across the United States.

Functions and Activities

- WFM serves the Veteran by offering and/or providing our customers' organizations with all aspects of employee life-cycle and organizational support to enable them to focus on achieving their business objectives.
- Builds a winning organization our customers can rely on and where our employees have opportunity for growth and advancement, and feel what they do is important.
- Hires, trains, and retains separate staffs.

Budget and Finance

Overview

OCC Budget, Finance and Contract Support organization supports the functions related to Revenue Operations and Purchased Care. Additionally, OCC Budget and Finance supports the OCC Headquarters business lines to include Business Policy, Workforce Management, Strategy and Performance Management and Executive staff.

Functions and Activities

- Administers and oversees the overall Community Care budget of more than \$10B, 7500+FTE.
- Oversees OCC-wide contracts.
- Manages and administers VACO OCC SharePoint sites, Continuity of Operations Plan (COOP), building and emergency management and training.
- Manages and oversees the OCC travel portal with standard application in all OCC organizations.

Business Policy

Overview

Business Policy establishes and maintains effective partnerships in promoting programs and initiatives that enhance service to Veterans. This includes development and implementation of Regulations, Handbooks, VHA Directive and Procedural Guides that support and facilitate VHA facility's staff ability to provide services to Veterans, their families and other beneficiaries.

Functions and Activities

- Coordinates annual Legislative Proposal call for Community Care.
- Develops technical advice for introduced Congressional bills.
- Maintains Policy Questions & Answer Database.

- Maintains the Policy Guide Portal, which provides detailed guidance on how to implement directives and handbooks.
- Develops training for field staff on new or existing policy topics to ensure consistent application.
- Develop Fact Sheets and brochures on Policy topics.
- Develops Frequently Asked Questions (FAQ).
- Develops Legislative Proposals including impact analyses.
- Collaborates with Office of Regulatory Affairs on development on regulatory changes for administrative programs.
- Provides information with Veteran Service Officer (VSO) communities at VSO meetings and State and County Service training events, and.
- Researches and responds to Veterans questions and concerns.

Strategy and Performance Management

Overview

The Office of Strategy and Performance Management (OSPM) is aligned under the Office of Community Care (OCC). OSPM is the strategic arm of OCC, with responsibility for managing and coordinating Strategy, Enterprise Risk Management and Performance Improvement. OSPM serves OCC by supporting strategic efforts across of the OCC's Business lines: Revenue Operations and Purchased Care, as well as the offices of Workforce Management, Budget and Finance and Business Policy. OSPM manages OCC's strategic planning activities by working collaboratively with VHA and VA Strategic Planners.

Functions and Activities

- Oversees Enterprise Risk Management function.
- Develops and maintains the Strategic Plan and Operating Plan.
- Coordinates the development and maintenance of balanced scorecards.
- Provides helpdesk services for balanced scorecards and associated software.

Operations

Overview

Operations/Chief Business Office provides sustained revenue cycle management by applying industry proven methods, processes and business tools that enhance Veterans health care.

Functions and Activities

- Seven consolidated centers across the country perform back-end revenue cycle processes while each VAMC maintains ownership of key Veteran-facing activities.

- Manages the design of programmatic and technical capabilities required by industry EDI standard-setting organizations to communicate electronically with the commercial industry for the collection of MCCF and non-MCCF revenue from third party payers.
- Supports the electronic transaction technology platform capability and transaction processing with other Federal agencies and clearinghouses.
- Monitors key revenue cycle metrics.
- Provides standardization and model efficiencies to demonstrate progress toward achieving increasingly challenging targets.
- Supports payer relations activities with private sector health insurance companies at the national and regional levels.
- Oversees activities related to business process standardization through policy analysis, business information, operational risk management and internal controls, performance management, quality assurance monitoring and continuous process improvement.
- Develops business requirements, provides business engineering management, and implements innovative solutions to improve revenue operations effectiveness and efficiency.

OCC Systems Management

Overview

OCC Systems Management, located in Atlanta, G, is responsible for defining realizable solutions for intra/inter-agency business initiatives sponsored by Member Services to ensure Veterans access to their health benefits and services while achieving operational efficiencies.

Functions and Activities

- Develops strategies and solutions to implement legislative and high-priority initiatives such as Affordable Care Act, Enterprise Identity and Access Management (IAM), VHA PIV Only Authentication, and interoperable Electronic Health Record (either).
- Provides Senior Program and project management services for programs aimed to facilitate access to health care, support patient care, and ensure a seamless transition of Service members into a Veteran life, such as Fix the Phones Patient Aligned Care Teams (Ft. PACT), Health care Enrollment, Veteran Online Application for health benefits, Income Verification Modernization, and Veterans Financial Assessment.
- Performs detailed business analysis to streamline operational processes and deliver improvements to VHA's interactions with our clients such as Consolidated Copayment Processing Center statements, Veterans Health Benefits Handbook, and Secure Messaging for Billing and Copay.
- Conducts business integration activities to ensure VHA's processes are supported by accurate, meaningful, and trusted information such as enterprise member services and data integration, which includes Military Service Data Sharing, and Customer Data Information (CDI).

- Designs and performs functional testing activities to ensure technical solutions deliver the expected business benefits.
- Delivers business engineering solutions that are flexible, innovative, secure, and adaptive to facilitate VA services. Solutions include the Electronic VHA Disability Benefits Questionnaires (DBQs), Separation Health Assessments (SHA), Contracted Exam Solution, Homeless Stand Downs, and Veterans Transportation Services Portal (Web-based display of compiled beneficiary travel information).
- Sponsorship for the Program Application Support (PAS) Council.

Office of Community Care Purchased Care

Overview

Office of Community Care Purchased Care (OCCPC) is managed by the Deputy Chief Business Officer for Purchased Care located in Denver, Colorado and supports the delivery of health care benefits through enterprise program management and oversight of Purchased Care functions. This includes overall management of Health Care Payer Programs, which involves developing legislative, regulatory, and policy standards for programs and, managing, monitoring, controlling and auditing all program areas.

OCCPC manages the operational components to include eligibility, enrollment, and claims processing for the Civilian Health and Medical Program of VA (CHAMPVA) the Family Caregiver Stipend Program and Community Care (CC) to include: Veterans Access, Choice and Accountability Act (Choice), Patient-Centered Community Care (PC3), Project Access Closer to Home (ARCH), State Home Per Diem Program (SHPD), Indian Health Services and Tribal Health Program (IHS/THP), Camp Lejeune Family Member Program (CLFMP), Spina Bifida Health Care Program (SBHP), Foreign Medical Program (FMP), and the Children of Women Vietnam Veterans Health Care Program (CWVV). OCCPC provides enterprise wide business policy and standards, and appropriate business and systems support for all program areas. The following are the program descriptions: .

Community Care (CC) is provided to eligible Veterans outside of the VA when VA facilities are not feasibly available. CC medical care under Title 38 United States Code (U.S.C.) authorizes payment or reimbursement to a claimant for emergency treatment provided to Veterans meeting specific eligibility criteria. It also authorizes routine outpatient medical services, and certain inpatient services, through community providers. All community services must be preapproved before a Veteran receives treatment.

Functions and Activities

- Veterans Access, Choice and Accountability Act (Choice) was initiated on November 5, 2014. The new Veterans Choice Program covers community care for eligible Veterans enrolled in VA healthcare. Generally, Veterans are eligible if they need to wait more than 30 days from the clinically indicated date determined by their VA physician or reside more than 40 miles from the closest VA health care facility.
- Patient-Centered Community Care (PC3) is a program that contracts with vendors to develop a network of health care providers to deliver covered care to Veterans. The covered care includes primary care, inpatient specialty care, outpatient specialty care, and mental health care, limited

emergency care, limited newborn care for enrolled female Veterans following delivery, skilled home health care, and home infusion therapy.

- Project ARCH was originally a 3-year pilot program to provide specific community care services through contractual agreements to eligible Veterans in Veteran Integrated Service Networks (VISNs) 1, 6, 15, 18 and 19. With the adoption of the Veterans Access, Choice and Accountability Act of 2014 (P.L. 113-146), the Project ARCH pilot program has been extended for two additional years, now ending in August 2016. Project ARCH intends to improve access to health care services for eligible Veterans by connecting them to services closer to their home in each of the five VISNs, located in Northern Maine; Farmville, Virginia; Pratt, Kansas; Flagstaff, Arizona; and Billings, Montana.
- The State Home Per Diem Program oversees program policy associated with the application, eligibility, and authorization for claims processing and provision of grant per diem funds associated with the use of State Veterans Homes. The Program provides an economical alternative to constructing, maintaining and operating VA facilities for the provision of care to eligible Veterans and establishes annual State Home Per Diem payment rates.
- The Tribal Reimbursement Agreements Program provides a means for Indian Health Services (IHS) and Tribal Health Program (THP) health facilities to receive reimbursement from the VA for direct care services provided to American Indian and Alaskan Native eligible Veterans. The Office of Community Care Purchased Care, Office of Tribal Government Relations (OTGR), and VA Medical Centers (VAMCs) work together to implement the Tribal Reimbursement Agreements Program. This program is part of a larger effort set forth in the VA and IHS Memorandum of Understanding, signed in October 2010, to improve access to care and care coordination for our nation's Native Veterans.
- Eligibility Enrollment and Verification (EEV): Oversees the application and verification process for certain family members of a qualified Veteran that is not eligible for DoD Tricare health care benefits. CHAMPVA provides reimbursement for medical services and supplies for the spouse, surviving spouse, or child of a Veteran who (a) has a permanent and total service-connected disability, (b) died as a result of a service-connected disability, (c) was permanently and totally disabled from a service-connected condition at the time of death, or (d) has died during Active Duty.
- The Spina Bifida Health Care Program (SBHP) provides reimbursement for services and supplies for Vietnam and Korea Veterans' birth children diagnosed with spina bifida.
- The Children of Women Vietnam Veterans (CWVV) Health Care Program provides reimbursement for medical services and supplies for children with VBA-adjudicated birth defects born to women Vietnam Veterans.
- The Foreign Medical Program (FMP) is for Veterans who reside or are traveling outside the United States (excluding the Philippines). Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected diagnosis.

- OCCPC comprises eight Directorates: Community Care Operations (CCO), Program Oversight and Informatics (POI), Customer Experience (CE), Business Systems Management (BSM), Claims Adjudication and Reimbursement (CAR), Purchased Care Way Forward (PCWF), Chief Financial Office (FM) and Resources (RES).

OCCPC Directorates

Community Care Operations

Overview

The Community Care Operations Directorate (CCO) provides management, oversight, and customer support for all Purchased Care programs.

Functions and Activities

- CCO Directorate processes eligibility and enrollment decisions for standard CHAMPVA, Caregiver CHAMPVA, Spina Bifida Health Care Program (SBHP), Camp Lejeune Health Care Program (CLFMP), CWV Health Care Program, and the Foreign Medical Program (FMP).
- In addition to eligibility determinations, CCO manages and provides oversight to critical programs outlined below.

National Community Care Program Office

Overview

The National Community Care Program Office (CCPO) formerly known as National Non-VA Medical Care Program Office (NNPO) provides administrative support and guidance to VHA OCC on the business aspects of Community Care operations. CCPO, while based in Denver, Colorado, is organizationally aligned under the Veteran Health Administration's OCC, located in Washington, D.C. CCPO assists with the development of community medical care related regulations located in 38 CFR 17, and provides concurrence and comment as requested by other entities within and outside of VA regarding policy, regulation, or statute pertaining to community medical care.

Functions and Activities

- Provides administrative guidance to VHA OCC for purchased care.
- Disseminates business process guidance and supports the Business Systems Management (BSM) Office, which is responsible for the business development and maintenance of the VistA Fee, Central Fee, Fee Payment Processing System, and Fee Basis Claims Systems (FBCS).
- Provides guidance to field operations to ensure the lifecycle of community medical care is executed accurately and that all community medical care stakeholders are satisfied when utilizing this program.
- Leverages leadership and stakeholder relationships to improve process planning and implementation efforts.
- CCPO's role in the field includes coordination of policies, business systems, and program information resources to support VAMCs and clinics purchasing treatment for their Veterans from the community and is provided through varied revenues.

Field Assistance**Overview**

Field Assistance (FA) and Program staff supports efforts to improve internal controls for field sites regarding community medical care claims processing activities and the Community Care Coordination Offices (CCCO) regarding the referral and authorization processes of authorizing community care.

Functions and Activities

- Conducts field assistance to VA facilities Purchased Care Offices in an effort to improve claims processing practices, which includes financial management, FBCS processing oversight and data analysis.
- Conducts field assistance to VA facilities Community Care Coordination (VCCCO) Offices in an effort to improve the referral and authorization of community care processing practices, which includes financial management, PC3 and Choice referral processes to include the utilization of the Third Party Administrator (TPA) portal of communication, and FBCS processing oversight and data analysis.
- Provides training programs and courses on new processes and guidance of oversight tools for local Community Care Program Offices on a scheduled, or by-request basis, on-site and virtually.
- Provides facility site reviews to assess claims processing, referral and authorization processes.
- Disseminates guidance, training and programmatic communication to field Purchased Care Offices.
- Provides research and responses to process oriented and technical inquiries submitted from field Purchased Care Offices.
- Provides support to claims processing systems (FPPS/EDI, VistA Fee and FBCS) and system information to ensure specialized pricing schedules are updated and supported.

Provider Management**Overview**

The Community Care Provider Management Office (CCPMO) is the focal point within VHA monitoring community provider topics and coordinating efforts to strengthen and improve the network of community providers engaged with VHA. The office builds and sustains a robust and informed provider network by adopting a proactive outreach and education strategy designed to enhance strategic partnerships.

Functions and Activities

- Conducts outreach to promote awareness and use of Community Care programs with emphasis on PC3 contracts.
- Maintains a Community care provider list for PC3/CHOICE providers, reporting on specialty and service area volume.

- Manages external facing websites for Veteran stakeholders that maps provider locations and hosts other information and resources.
- Educates and provides training resources available for community care providers.
- Works closely with Community Care Support Office (CCSO), policy, and field units to ensure that the PC3/CHOICE provider networks are meeting the capacity and quality needs of VHA.

Camp Lejeune Health Care Program Office

Overview

The Camp Lejeune Health Care Program (CLFMP) provides health care/benefits for 15 medical conditions to Veterans and family members who were stationed or resided at Camp Lejeune, North Carolina for more than 30 days from August 1, 1953, through 1987.

Functions and Activities

- Manages the operational components to include eligibility, enrollment, and claims processing for the Camp Lejeune Family Member Program.
- Works in partnership with VA Health Eligibility Center (HEC), VA Benefits Administration (VBA), and the U.S. Marine Corps to determine CLFMP family member administrative eligibility.
- Works in partnership with VA Office of Public Health (OPH) and WRIISC for appropriate clinical determinations for the 15 covered medical conditions.
- Develops policy and operational processes and procedures.
- Provides communication and training to internal and external stakeholders.
- Analyzes and audits claim data and financial processes.

State Home Per Diem Program Office

Overview

State Home Per Diem (SHPD) Program oversees program policy associated with the application, eligibility, and authorization for claims processing and provision of grant per diem funds associated with the use of State Veterans Homes. The Program provides an economical alternative to constructing, maintaining and operating VA facilities for the provision of care to eligible Veterans. SHPD establishes annual State Home Per Diem payment rates, assists in the development or implementation of per diem payment regulations and legislation, and provides grant per diem funding to VA Medical Centers of Jurisdiction to reimburse State Veterans Homes for Veteran care.

Functions and Activities

- Responds to inquires pertaining to State Home Per Diem issues.
- Provides information and assistance to the National Association of State Veteran Homes and the National Association of State Directors of Veterans Affairs.
- Establishes annual State Home Per Diem payment rates.

- Assists in the development and implementation of per diem payment regulations and legislation.
- Provides grant per diem funding to VA Medical Centers of Jurisdiction to reimburse State Veterans Homes for Veteran care.
- Prepares and provides training to field staff and State Veteran Homes monthly and quarterly.

Project Access Received Closer to Home Office

Overview

Project Access Received Closer to Home (ARCH) is a 3-year pilot program implemented through Section 403 of P.L. 110-387 and amended by Section 308 of P.L. 111-163, which helps eligible rural Veterans get the medical care they need closer to where they live through competitively awarded contracts.

Functions and Activities

- Implements care management strategies, proven valuable in public and private sectors.
- Ensures care purchased for eligible enrollees from community providers is effective and complementary to the larger VHA system of care.
- Establishes at least five care management demonstration programs through competitive awards in VISNs 1, 6, 15, 18, and 19.
- Comprehensive assessment will evaluate volume of care, access to care, quality of care, and cost of care with final report due fall of 2016.

Community Care Support Office

Overview

Community Care Support Office (CCSO) develops and functionally maintains contractual relationships with a variety of community (private sector) providers and health care systems across the nation promoting health and safety quality metrics and price competition.

Functions and Activities

- Patient-Centered Community Care (PCCC or PC3) contract oversight – VHA effort to create an enterprise wide health care contracting strategy. PC3 will provide eligible Veterans coordinated, timely access to care through a comprehensive network of community providers who meet VA quality standards when VA cannot provide the care in-house.
- Choice contract oversight - Contract oversight of implementation of P.L. 113-146, the Veterans Access, Choice, and Accountability Act of 2014. The Choice Program covers hospital care and medical services under the Medical Benefits Package. All care under the Choice Program must be pre-authorized. The Choice Program does not include Nursing Home Care or unscheduled (emergency) community care.
- Dialysis National Contracts oversight – Coordination of Contracts that offer Veterans access nationwide (including rural and highly rural geographies) to community-based dialysis care as

demand increases in the Veterans and general populations. Contracts were awarded June 14, 2013 to 23 Dialysis/End Stage Renal Disease companies.

Spina Bifida Health Care Program Office

Overview

The Spina Bifida Health Care Program (SBHP) provides reimbursement for services and supplies for Vietnam and Korea Veterans' birth children diagnosed with Spina Bifida.

Functions and Activities

- Enrolls eligible beneficiaries in the program. (Eligibility is established by the Veterans Benefits Administration).
- Manages all SBHP activities, including planning, organizing, budgeting, directing, coordinating, evaluating, and improving administrative operations.

Customer Experience Directorate

Overview

The Customer Experience Directorate (CE) provides customer support and stakeholder relations management for all Purchased Care programs. This includes the family member programs; standard CHAMPVA, Caregiver CHAMPVA, Spina Bifida Health Care Benefits Program (SBHP), Camp Lejeune Health Care Program (CLFMP), Children of Women Vietnam Veterans Health Care Benefits Program (CWVV) and the Foreign Medical Program (FMP). In addition, CE provides customer support for Veterans who receive care in the community and for providers of that care.

Functions and Activities

- Manages an inbound call center which responds to inquiries for all aspects of the family member programs to include eligibility, claims processing/payments, benefits and appeals.
- Manages an inbound call center which responds to claims processing inquiries from Veterans and providers of their medical care in the VISN 16 area.
- Manages the Adverse Credit Hotline with a goal of resolving issues for Veterans who have been threatened with collections as a result of non-payment of claims for care received in the community.
- Manages surveys and stakeholder feedback/input for all Community Care programs.

Customer Service Center

Overview

When a Veteran is not eligible for DoD Tricare health care benefits, CHAMPVA provides reimbursement for medical services and supplies for the spouse, surviving spouse, or child of a Veteran who (a) has a permanent and total service-connected disability, (b) died as a result of a service-connected disability, (c) was permanently and totally disabled from a service-connected condition at the time of death, or (d) has died during Active Duty.

Functions and Activities

- Verifies eligibility for Standard and Caregiver CHAMPVA benefits.
- Operationally manages the program, including overall planning, organizing, budgeting, and directing, coordinating, evaluating, and improving administrative operations.

Program Oversight and Informatics (POI) Directorate

Overview

Program Oversight and Informatics (POI) Directorate ensures that VA health care program dollars do not pay for fraudulent or abusive services and supplies. POI reduces operating costs resulting in more benefits and better quality of care for Veterans and their dependents by establishing specialized programs to monitor all related business operations. POI ensures all claims are paid properly. Improper payments for all programs are tracked to ensure recovery of overpayments. Audit findings and Corrective Actions are identified and tracked to demonstrate improvement and reduction of improper payments. POI provides data analytics and reporting for all VACC programs.

Functions and Activities

- Provides Quality Oversight, Analysis, and Investigative Research of Improper Payments for OCCPC Programs.
- Serves as the oversight entity for all OCCPC programs to combat fraud, waste and abuse issues.
- Conducts internal controls testing for all OCCPC programs resulting in the annual Statement of Assurance (A-123) and conducts/coordinates program risk assessment.
- Conducts the IPERIA audits for four programs: State Home Per Diem, CHAMPVA, Community Care, and Choice as well as special and recurring audits for all OCCPC programs.
- Provides requested or routinely needed information/data and analysis for each Community Care program.
- Uses a variety of statistical techniques to analyze current and historical transaction data to make predictions or provide predictive scores (probability) relating to future events in order to determine, inform, or influence organizational processes.
- In accordance with the Records Management policy maintains compliance with records collection maintenance and retention.
- Collaborates with OCCPC program owners to develop measurable corrective action plans and identify sources of data that can be used to objectively assess success.
- Reviews and incorporates all reports from internal and external auditing sources into the Quality Corrective Action Plan (QCAP) operating system for tracking, trending, and reporting.
- Provides support, coordination, and tracking of progress to ensure successful completion of corrective action plans.

- Serves as the OCCPC point of contact with VHA Financial Assistance Office (FAO) for Improper Payments Elimination and Recovery Act (IPERIA) corrective action plan development, implementation, status updates, and completion.
- Reviews corrective action plans and measurable outcomes to determine degree of success realized by the corrective action plan.

Department of Program Integrity

Overview

Department of Program Integrity provides investigative analysis and reports on fraud detection, research, and operations. Program Integrity oversees the development, testing and development of tools that identify potential improper payments in a pre-payment state, thereby reducing the improper payment rate, enhancing program effectiveness, and demonstrating significant cost avoidance.

Functions and Activities

- Provides Quality Oversight, Analysis, and Investigative Research of Improper Payments for OCCPC Programs.
- Serves as the oversight entity for all OCCPC programs to combat fraud, waste and abuse issues.
- Promotes payment integrity through the identification and monitoring of potential improper payments in a pre-payment state, thereby, reducing the improper payment rate.
- Oversees the partnership and interactions with key stakeholders regarding all program integrity matters.
- Develops and implements key measures to carry out Program Integrity's mission and ensure program weaknesses are identified and resolved.

Department of Audits and Internal Controls

Overview

Department of Audits and Internal Controls (DAIC) performs extensive audits and internal controls testing on all Purchased Care Programs to ensure compliance with policies, laws, regulations, and contracts and that controls are in place to improve program effectiveness.

Functions and Activities

- Conducts the IPERIA audits for four programs: State Home Per Diem, CHAMPVA, CC, and Choice as well as special and recurring audits for all OCCPC programs.
- Conducts internal controls testing for all OCCPC programs resulting in the annual Statement of Assurance (A-123) and conducts/coordinates program risk assessment.
- Supports and facilitates open communication regarding OCCPC's internal control efforts to new or revised business processes, procedures, policies, communication efforts, and external reports.

- Supports and facilitates open communication regarding OCCPC's audit findings, and corrective actions.
- The Recapture Program tracks resolution of improper payments identified either by audits, or other external or internal reviews.
- Manages the Recovery Audit Contract which audits claims, tracks debt collections of identified overpayments, and returns collections to VHA.

Department of Informatics

Overview

Department of Informatics is responsible for monitoring, reporting, and managing the vast amount of health care data associated with the Purchased Care Programs. These program functions afford VHA insight into the health care purchasing trends, assure appropriate care is purchased and provide key indicators concerning service delivery to our Veteran and beneficiary population.

Functions and Activities

- Provide requested or routinely needed information/data and analysis for each Community Care program including Community Care (CC) (traditional Fee), Patient Centered Community Care (PC3), Access Received Closer to Home (Project ARCH), Veterans Access, Choice and Accountability Act (VACAA/Choice), Civilian Health and Medical Program of VA (CHAMPVA), Foreign Medical Program (FMP), Camp Lejeune Family Member Program (CLFMP), Spina Bifida Health Care Program (SBHP), Caregiver Support Program and State Home Per Diem.
- Track trends and provide metrics for each CC program to afford VHA insight into the health care purchasing trends to assure appropriate care is purchased and provide key indicators concerning service delivery to our Veteran and beneficiary population.
- Partner with the CC business lines as well as other VA entities to create, develop and maintain tools needed to enhance the operations and monitoring of CC programs to help ensure proper payments and appropriate use of government funds.
- Uses a variety of statistical techniques to analyze current and historical transaction data to make predictions or provide predictive scores (probability) relating to future events in order to determine, inform, or influence organizational processes that pertain across large numbers of individuals, such as in patient outcomes, fraud detection, and government operations.
- Conducts VA CC data pulls and reporting for all facets of VA, provide assistance and guidance to executive leadership, engage in statistical and analytical projects, and coordinate VA and VHA leadership for routine or ad hoc data needs.
- Participates in strategic planning, quality management and data quality initiatives for the entire agency incorporating key data sets into critical business planning decisions.

Department of Privacy and Information Management**Overview**

Department of Privacy and Information Management is responsible for the oversight, maintenance, retention and release of information from VA Community Care. Oversight of the Freedom of Information Act (FOIA), Privacy Act, Records Management and Forms Management programs support VA Community Care personnel, veterans, beneficiaries and providers.

Functions and Activities

- In compliance with the Open Government Act process FOIA requests responsive to news media, congressional and individual requests regarding claims processing.
- In accordance with the Privacy Act administratively process, investigate and report privacy violations, offer notification and credit monitoring. In accordance with Business Associate Agreements process privacy violation/incident reports associated with contracts.
- In accordance with the Privacy Act Program DPIM processes individual requests for information, review contract data security, process Privacy Threshold Analysis and Privacy Impact Assessments, conduct Social Security Reduction reviews and action plans, and monitors annual privacy training of over 3,000 VA Community Care employees.
- DPIM manages the collection, retention, storage, release, and disposition of records created in the course of business for VA Community Care. Maintain a NARA account, document disposal, file plans, vital records, contracting clearance, and training.
- Develop local forms in Adobe fillable PDF which are 508 compliant, administratively track and maintain a master list.

Business Systems Management Directorate**Overview**

Business Systems Management (BSM) Directorate is responsible for the re-engineering, implementation, and management of innovative business solutions to improve the effectiveness and efficiency of Purchased Care's business lines and enhance Veteran health care. BSM takes a portfolio approach to manage and enhance Purchased Care business lines.

Functions and Activities

- Implements and manages business solutions to ensure care in the community medical care is coordinated, and the health care claims are paid accurately and in a timely manner.
- Responsible for the management, implementation, and enhancements of the following systems and processes:
- Fee Basis Claims System (FBCS) that supports more than \$4 billion a year in claims payments.
- Claims Processing and Eligibility System (CPES) and Caregiver Stipend Payment System that supports more than \$1 billion a year in claims payments.
- Program Integrity Tool (PIT) that supports detection of fraud, waste, and abuse.

- Health Claims Processing System will replace the multiple claims processing systems into one consolidated system.
- Electronic Data Interchange (EDI) systems to meet objectives in HIPPA.
- Coordinate Community Care programs to ensure medical care is properly authorized.
- Develops strategies and solution to implement legislative and high-priority initiatives such as Camp Lejeune, Affordable Care Act, ICD-10, Caregiver, Indian and Tribal Health Program, Purchased Care National Contracts, VLER, etc.

Program Management Office

Overview

The Portfolio Management Team Serves as the OCCPC enterprise project and program element. The team utilizes comprehensive project management framework and principles based upon industry standards established by both the Project Management Institute or PMI and VHA IT partners leveraging the PMAS project standards. Centralizes and coordinates the management of projects supporting Purchased Care Business lines.

Functions and Activities

- Centralizes and coordinates the management of projects supporting Purchased Care business systems utilizing a comprehensive project management framework to support standard project management practices.
- Provides project and program management functions to include scheduling, risk and issues management, stakeholder management, business-oriented software development life-cycle support, product and process deployment, return on investment analysis and benefits realization.
- Develops and establishes a comprehensive project management framework and training programs to support standard project management practices.

Business Process Re-engineering Office

Overview

Business Process Re-engineering Office (BPRO) is responsible for improving, enhancing Purchased Care business process efficiencies through requirements management, business modeling, requirements tracing, User Acceptance testing (UAT) and project implementation support to the portfolio. The team leverages a doctrinal approach that runs parallel to both unified modeling language standard as well as those guidelines supported by the Business Analysis Body of Knowledge or (BABOK).

Functions and Activities

- Responsible for improving business processes to align all aspects of the organization with Purchased Care to promote business effectiveness and efficiency, while striving for innovation, flexibility, and integration with technology.
- Business Standards and Requirements Management.

- Tracing and Elaboration of Business Requirements into more detailed software driven needs.
- Development of Decision Support Tools.
- Management of User Acceptance Testing to ensure technical solution delivers the expected business benefits.
- Change Control Management.

Optimization and Standardization Department

Overview

Optimization and Standardization Department (OSD) is responsible for the evaluation of existing processes, system limitations and procedures to identify opportunities for process and technical improvement leveraging readily available technology and resources. OSD serves as the BSM / OCCPC Tools management entity; those tools built to support business function in the absence of IT funding and support.

Functions and Activities

- Responsible for the evaluation of existing processes and procedures to identify opportunities for process improvement that leverage available industry strong practices using readily available technology and resources.
- Development and management of operational efficiency tools to include tools based in SharePoint, HTML, Macros and other solutions.
- Statistical and manpower analysis.
- Management of analytical assessments.
- Process evaluation and documentation.

Clinical Business Systems Office

Overview

Clinical Business Systems Office (CBSO) is responsible for the delivery of innovative and patient-centric business solutions to ensure high quality, coordinated, and equitable delivery of community patient care.

Functions and Activities

- Responsible for the delivery of innovative and patient-centric business solutions to ensure high quality, coordinated, and equitable delivery of community patient care.
- Clinical Business Process Re-engineering.
- Manages clinical projects.
- Liaises with CC clinical field personnel and clinical VHA offices.

- Provides oversight and support of clinical elements of BSM projects.

Claims Adjudication and Reimbursement Directorate

Overview

The 2,300 staff members in the Claims Adjudication and Reimbursement Directorate (CAR) processes payments and resolves claims' issues for VA healthcare benefits for Veterans and family members for CHAMPVA, Spina Bifida Health Care Program (SBHP), Camp Lejeune Health Care Program (CLFMP), Children of Women Vietnam Veterans Program (CWVV), Caregiver Support Stipend Program, Foreign Medical Program (FMP) and VA Community Care Program. Additionally, the Directorate manages resolution of all Veteran, beneficiary, and provider issues by responding to inquiries sent through the Secretary's office, Congressional offices, and the Customer Service Center.

Functions and Activities

- VA Community Care (VACC) is medical care provided to eligible Veterans outside of the VA when VA facilities are not available. All VA medical centers can use this program when needed. The use of VACC as a means to provide care in the community to Veterans is governed by federal laws containing eligibility criteria and other policies specifying when and why it can be used. A pre-authorization for treatment in the community is required unless the medical event is an emergency. Emergency events may be reimbursed on behalf of the Veteran in certain cases.
- The Foreign Medical Program (FMP) is a program for Veterans who live or travel overseas. Under the FMP, the VA will pay the VA allowable amount for covered services for a VA adjudicated service-connected disability.
- The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries.
- The Spina Bifida Health Care Program (SBHP) is a health benefits program administered by VA for Vietnam and certain Korea Veterans' birth children who have been diagnosed with spina bifida (except spina bifida occulta). Under SBHP, comprehensive health care considered medically necessary and appropriate is covered.
- The Children of Women Vietnam Veterans (CWVV) Health Care Program is a health benefits program administered by VA for children with certain birth defects born to women of Vietnam Veterans. The CWVV Program provides reimbursement for medical care related to conditions associated with certain birth defects except spina bifida, which is covered under SBHP.
- The Camp Lejeune Family Member Program (CLFMP) is for family members of Veterans who were stationed at Camp Lejeune between August 1, 1953, and December 31, 1987. During this time, Veterans and family members living or serving at U.S. Marine Corps Base Camp Lejeune, North Carolina, were potentially exposed to drinking water contaminated with industrial solvents, benzene and other chemicals.
- Caregiver Stipend Program: Under the Caregivers and Veterans Omnibus Health Services Act of 2010, VA services are available seriously injured post-9/11 Veterans and their Family Caregivers through the program of Comprehensive Assistance for Family Caregivers. The Caregiver Support

Office is responsible for the administration of monthly stipend benefits to include initial stipend benefit calculation and payment, processing recurring monthly stipend benefits, and administration of all updates/changes related to the stipend. The Caregiver Support Office also enrolls those eligible Primary Family Caregivers with no health care coverage into CHAMPVA.

Purchased Care Way Forward Directorate

Overview

Purchased Care Way Forward (PCWF) Directorate is responsible for future-state transformative initiatives within the Office of Community Care Purchased Care (OCCPC). The Directorate manages strategic initiatives commissioned to standardize execution, management and oversight of community care (CC) programs in response to legislation and senior VHA leadership guidance.

PCWF is tasked with delivering a timely, accurate, and efficient enterprise business solution to maximize the healthcare dollars available for Veteran care. PCWF manages three improvement initiatives to better serve Veterans through accurate payments, well-supported and trained Community Care employees and enhanced stewardship of taxpayer dollars. Initiatives include:

Functions and Activities

- Through the Program Management Office, provides cross-directorate program and project management support and facilitation in support of CC priority efforts, and Project management and scheduling support for high-priority initiatives (e.g., Alaska Scheduling Pilot, Provider Agreements, etc.).
- Develops OCCPC strategic communications outreach materials for affected internal and external stakeholders, develops national union notification materials and provides recommended courses of action for systems and process roll-outs.
- Through Community Care National Standardization, develops standardized business processes and solutions for designated CC programs and functional areas. Provides standardized process for functional areas to align with system functionality provided by the Fee Basis Claims System (FBCS), Healthcare Claims Processing (HCP) system modules, and future claims processing systems.
- Reinforces process standardization effort of Community Care Coordination (CCC).
- Through Future State Claims Processing System, modernizes and streamlines multiple system components into a capable enterprise healthcare claims processing system for OCCPC to increase claims processing efficiency and accuracy.
- Deploys commercial off-the-shelf (COTS) system technology to support CC improvements by replacing aging, decentralized software with an enterprise claims processing solution used by all sites and reduces or eliminates variation across CC claims processing to increase processing efficiency and accuracy.
- Provides system functionality to align with process changes previously implemented as part of the CCC project.

PCWF Consolidation**Overview**

The Veterans Access, Choice, and Accountability Act (VACAA) of 2014, Section 106, required VA to transfer authority to pay for hospital care, medical services and other health care through CC providers to the Office of Community Care (OCC) from VA's Veterans Integrated Service Networks (VISNs) and VA Medical Centers (VAMCs) effective October 1, 2014. This consolidated CC administrative authorization and payment processing activities under the line management of OCCPC.

Functions and Activities

- Leverages business and clinical process efficiencies achieved through consolidation of personnel to refine and implement standard processes, performance targets and monitoring to drive efficiency.
- Ensures processing activities are performed and measured consistently across the enterprise.
- Adopts new policies, corrects process issues and substantially reduces variability and error rates.
- Delivers exceptional customer service to Veterans and all OCCPC stakeholders.
- Manages the activities of Tiger Teams focused on hiring staff, eliminating the CC claims backlog, improving financial oversight, standardizing operations and improving CC customer service.
- Evaluates the CC footprint and make recommendations for restructuring OCCPC to sustain future CC operations to include development of a regional model that aligns with the OCCPC network structure.

Financial Management Directorate**Overview**

The Office of Community Care Purchased Care (OCCPC) Financial Management Department (FM) provides responsive and dedicated financial management in support of the OCCPC programs and initiatives.

Functions and Activities

- Budget Administration, to include planning, programming and budget implementation.
- Processes and approves financial transactions based on spend plans and financial guidance.
- Processes travel requests.
- Administers payroll, to include processing finance related payroll actions, provide customer service to all OCCPC employees, and provide support to timekeepers and supervisors.
- Accounting – compiles and verifies the accuracy of accounting data used to prepare statements and reports.
- Records financial transactions in the correct accounting period.

- Reconciles supporting documents to accounting records details and accounting record details to summary account balances.
- Administers OCCPC's end-to-end debt management process.

Resources Directorate

Overview

Resources Directorate (RES) is comprised of four Departments: Communications, Congressional Response, Logistics, and Quality and Workforce Development that provide all non-IT, non-HR, related support requirements for the entire OCCPC organization. This support directly or indirectly impacts the mission and goals of all people, projects and programs within the organization.

Department of Communications

Overview

Communications is responsible for internal/external communications within Purchased Care. Provides a litany of vital communications products and services.

Functions and Activities

- Public Affairs, Community and Media Relations; Public Speaking/Program Outreach (CHAMPVA, Foreign Medical Program).
- GPO contracting and printing management; Specialty printing (Braille, foreign language documents); In-house printing (limited due to VHA regulations, but we can still print certain unique items such as large posters, one off banners).
- Graphic Design (Magazines, posters, brochures, fact sheets, handbooks/guide books, promotional items, event signage, badges); Photography (event, official portrait, documentation); Videography (limited assets we generally use VA OPA or VAMC film crews).
- 508 Compliance conversions and testing; American Sign Language Interpretation (live interpretation, video phone management, ASL classes, ASL intern partnership); External ASL contract management (COR duties).
- Writing (news articles, press releases, speeches, information papers, fact sheets); Editing (copy editing and publications/layout editing); Binding and Lamination.
- Internet, Intranet and local web site management, review and construction.
- Spanish language translation (written and phone).
- Event Management (direct hiring events, VIP visits, specialty VA events); Health Event Management (blood drives, annual flu shot campaign); Publications storage and management (internal and federal center warehouse).
- American Sign Language Interpretation (live interpretation, video phone management, ASL classes, ASL intern partnership).

- External ASL contract management (COR duties).

Department of Congressional Responses

Overview

Creates official responses concerning Purchased Care issues for 50 percent of VHA facilities with intent to expand to 100 percent once adequate staffing is assured. Respond to inquiries from the White House, President and Vice-President. This also includes Cabinet Members, Members of Congress, State and County Officials, Veterans and beneficiaries. Assures responses address the inquiry and coordinates as necessary to assure that non-OCCPC matters are addressed.

Functions and Activities

- Congressional Response team members coordinate with other agencies to resolve problems affecting Veterans, beneficiaries, and health care providers.
- Facilitate correction of external, often long standing errors by creating Equitable Relief packages for approval of SECVA Title 38 U.S.C. Section 503.
- Manages official publications for the organization.

Department of Logistics

Overview

Manages non-IT equipment, workspaces, facilities, warehousing, space management, Personal Identity Verification (PIV) Card services, telework management, commuter program management, and serves as principal point of contact with contracting officials to assure our compliance and facilitate contracting matters.

Functions and Activities

- Schedules and services VA employees seeking issuance of PIV cards.
- Manages space allocation and requirements at micro and macro levels. Principal member of organization's Space Management Committee.
- Provides information and review materials for all Contracting Officer Representatives (CORs) to assure optimal oversight of this organization's contracts.
- Facilities management and coordination.
- Advises upon and archives memoranda of understanding with external entities.
- Manages security for VA employees in our leased space.
- Provides oversight and information related to Safety within the organization. Hosts numerous exercises and assures a safe workplace for all employees.
- Manages a medium-large warehouse that supports the equipment and supply needs of the organization.

Department of Quality and Workforce Development**Overview**

Hosts and has the capacity to train employees at centralized and decentralized locations upon request. Develops cutting edge training, and provides quantifiable results. Centralizes expertise in a host of areas, to include: training development, knowledge management, training delivery, e-Learning, Leadership, Organization Development, TMS Management and Change Management.

Functions and Activities

- Hosts numerous training classes in virtually every specialty and interest area of Purchased Care.
- Organizational Development specialists capable of effective organization design, upon request.
- Knowledge management reaches every employee in Purchased Care.
- Builds tomorrow's leaders by hosting numerous courses in leadership and management suitable for all levels of experience and for all grades.

Authorities

38 U.S.C. § 73 and applicable Subchapters I-IV

P.L. 93-82: Veterans Health Care Expansion Act

P.L. 99-272: The Consolidated Omnibus Budget Reconciliation Act of 1985

P.L. 104-262: The Veterans Health Care Eligibility Reform Act of 1996

P.L. 106-117: The Veterans' Millennium Health Care and Benefits Act

P.L. 107-135: The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001

P.L. 110-181: National Defense Authorization Act of 2008 (NDAA)

P.L. 110-387: Veterans' Mental Health and Other Care Improvements Act of 2008

P.L. 111-163: Caregivers and Veterans Omnibus Health Services Act of 2010

P.L. 112-154: Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012

P.L. 112-260 Dignified Burial and Other Veterans' Benefits Improvement Act of 2012

P.L. 113-146: Veterans Access, Choice and Accountability Act of 2014, as amended.

National Cemetery Administration

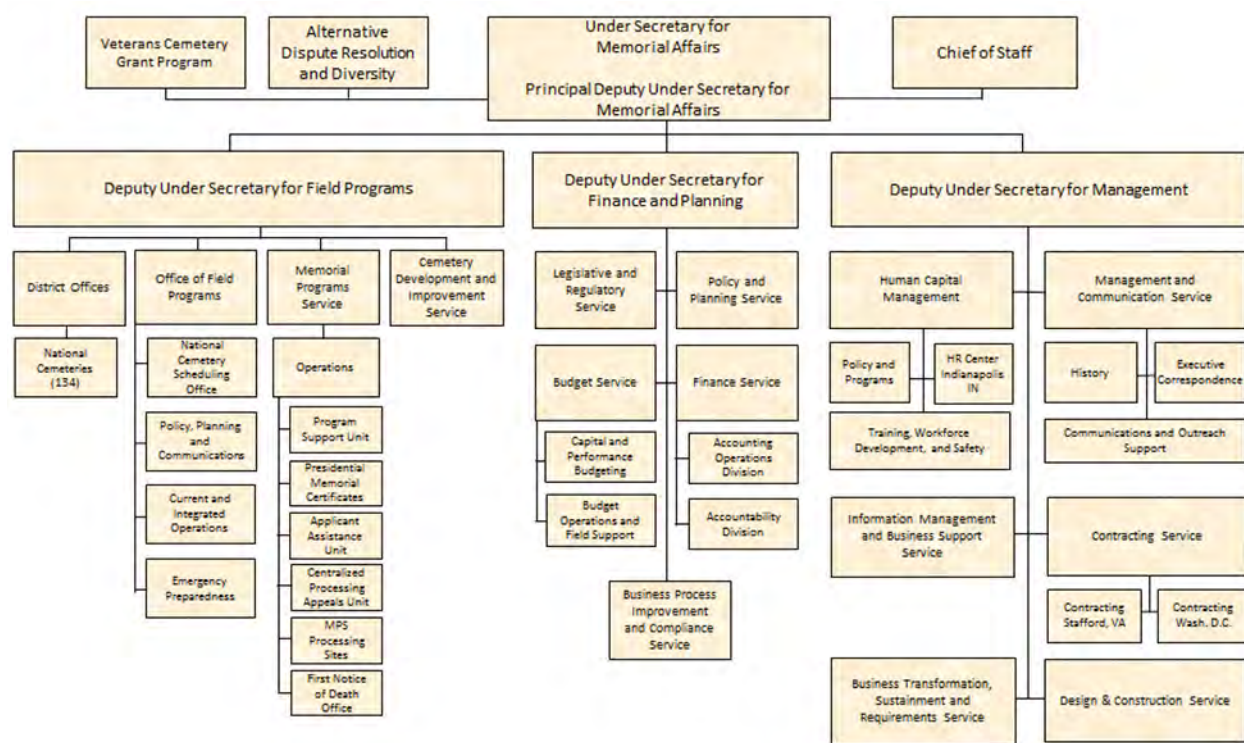


Figure 13 - National Cemetery Administration Organization Chart

[Click here for the alternate representation of the chart](#)

Mission

The National Cemetery Administration (NCA) honors Veterans and their families with final resting places in national shrines, and with lasting tributes that commemorate their service and sacrifice to our Nation.

Overview

The Office of the Under Secretary for Memorial Affairs (USMA) is responsible for the leadership and direction of NCA. The NCA inters eligible Servicemembers, Veterans and family members in VA national cemeteries and maintains the graves and their environs as national shrines in perpetuity; assists state and tribal organizations in providing burial benefits to Veterans through the Veterans Cemetery Grants Program; furnishes headstones and markers for graves in national, federally-administered state, tribal, and private cemeteries; furnishes medallions for privately purchased headstones and markers that signify Veterans' service; and provides Presidential Memorial Certificates to next of kin and other loved ones in recognition of Veterans' honorable service.

Office of the Under Secretary for Memorial Affairs

Overview

The Under Secretary for Memorial Affairs (USMA) provides leadership and direction for NCA, one of three administrations in VA. The USMA reports directly to the Secretary of Veterans Affairs and serves

as the principal advisor to the Secretary on matters including acquisition, construction and maintenance of national cemeteries, burial eligibility, the Headstone and Marker, Presidential Memorial Certificate and Veteran Cemetery Grants Programs. Additionally, the USMA is responsible for 134 national cemeteries and 33 soldiers' lots and monument sites throughout the country. The USMA serves as the Secretary's representative on matters relating to memorial entitlements programs and is committed to the priorities, goals and objectives of the Administration. The USMA represents the Secretary of Veterans Affairs at Congressional hearings, on the Advisory Committee on Cemeteries and Memorials, in ceremonial activities relating to national cemeteries and in other matters requested by the Secretary.

Functions and Activities

The Under Secretary for Memorial Affairs leads and directs the National Cemetery Administration. The Principal Deputy Under Secretary for Memorial Affairs oversees a broad range of management activities in support of the Under Secretary.

Administers U.S.C. Title 38 Benefits.

- Ensures a burial option exists for eligible Servicemembers, Veterans, Reservists, National Guard members and eligible family members in VA national cemeteries within a reasonable distance of their residence.
- Processes applications, procures and delivers headstones, markers, and medallions for the graves of Veterans throughout the United States and the world.
- Administers the Veterans Cemetery Grants Program, which provides grants to states and tribal organizations for establishing, expanding and improving Veterans' cemeteries.
- Provides Presidential Memorial Certificates to honor the service of honorably discharged deceased Servicemembers and Veterans.
- Maintains VA national cemeteries as national shrines.

Manages the National Cemetery Administration

- Develops and administers an annual budget for cemetery operations.
- Provides leadership and program direction to NCA's employees who are fulfilling NCA's unique mission functions nationwide.
- Formulates plans that lead to recommendations for Secretary of Veterans Affairs (SECVA) approval in regards to the establishment of new national cemeteries and expansion and improvement of existing cemeteries.
- Encourages high-level customer service standards as recognized by the national cross-industry American Customer Satisfaction Index (which measures satisfaction with the quality of goods and services available in the United States), such as courtesy, easy access to gravesite and benefits, prompt delivery of service and benefits, accuracy, and cemetery appearance that is befitting a national shrine.

- Effectively and efficiently serves Veterans, their families, NCA employees, and key stakeholders through crucial business functions, such as human resources, equal employment opportunity and diversity, budget/finance, construction, safety, emergency preparedness, information technology, outreach and communications.

Operates and Maintains VA National Cemeteries.

- Ensures adherence to National Shrine Operational standards at VA national cemeteries. National Shrine standards are set by NCA and are used as a benchmark by other Federal and state cemetery organizations.
- Provides policy and plans required for the development, operation, and administration of all VA national cemeteries.
- Plans for and acquires resources needed to ensure VA national cemeteries are maintained as national shrines to honor service to the Nation.

Advises the SECVA

- Advises on the development, adoption, and implementation of NCA programs and policies affecting overall operations of VA national cemeteries, and burial benefits administered by NCA.
- Represents the SECVA on the congressionally-authorized Advisory Committee on Cemeteries and Memorials.
- The Committee advises the SECVA, through the Under Secretary for Memorial Affairs (USMA), with respect to the administration of VA national cemeteries, and Veterans and Servicemembers' lots and plots.
- Advises the SECVA on erecting appropriate memorials and the adequacy of Federal burial benefits.
- Examines the full spectrum of available benefits and services and makes reports and recommendations on how to resolve issues involving the operations of the NCA, the Veterans Cemetery Grants Program, the provision of headstones, markers, and medallions, the provision of Presidential Memorial Certificates, and related burial benefits.
- Assists the SECVA in ensuring that plans and programs are meeting the needs of the Nation's Veterans and their eligible family members, and in meeting the mandate to maintain our national cemeteries as national shrines.

Stakeholder Engagement

- Manages relationships with NCA's diverse and varied stakeholder population, including Veterans and their family members, Veterans Service Organizations (VSO), and professionals in the funeral and mortuary industry.
- Includes environmental groups, historical groups, and genealogical organizations in stakeholder management activities, such as reviewing plans to establish or expand VA national cemeteries.

- Coordinates activities with various components of the DoD and members of Active-Duty and Reserve forces.
- Partners with DoD, American Battle Monuments Commission, U.S. Military Academies and National Park Service to ensure accurate and dignified burial of the Nation's heroes.
- Coordinates with states and tribal organizations to establish State and Tribal Veterans Cemeteries.
- Represents the SECVA and/or the VA at congressional hearings and in ceremonial activities relating to VA national cemeteries.

Authorities

38 U.S.C. § 2306

38 U.S.C. § 24

38 CFR Parts 38-39

OMB Circular A-123

Chief of Staff (40A1)

Overview

The Chief of Staff (COS) is a member of the NCA Management team, providing direct advice and high-level technical support to the Under Secretary and the Principal Deputy Under Secretary for Memorial Affairs, including the Senior Executive Service (SES) leadership team.

Functions and Activities

- Provides leadership and advisory services that are critical to achieving optimal overall program balance in relation to Department's mission.
- Promotes and maintains successful and productive interactions with a wide variety of entities.
- Liaise with the districts and national cemeteries, coordinates crosscutting tasks and is consulted for evaluation or assessment of documents, processes, correspondence, policies and more.
- Makes recommendations to ensure maximum effectiveness and efficiency in the use of all resources.
- Manages NCA's delegations of signature authorities for statutory and regulatory actions that Under Secretary for Memorial Affairs (USMA) and NCA staff are authorized to make.

Alternative Dispute Resolution and Diversity (40A2)

Overview

The NCA Alternative Dispute Resolution and Diversity (ADR&A) Office is responsible for the implementation of Title VI & VII Programs. The ADR&A oversees Equal Opportunity/Affirmative Employment (EEO/AE), Alternative Dispute Resolution (ADR), Diversity and Inclusion (D&I), and Civil Rights (CR) functions. This office provides support to NCA senior leaders, managers, and employees

nationwide on matters of diversity and inclusion, discrimination, equal employment, anti-harassment program, workforce recruitment, retention, reasonable accommodations, special emphasis programs, the national diversity internship program, and the NCA Minority Veterans Program Coordinator program. The DI&EEO Director and staff also serve as liaisons to the Office of Resolution Management (ORM), in matters of discrimination based on Title VI and VII, and serve as facilitators for addressing workforce diversity issues.

Functions and Activities

This office serves NCA headquarters, district offices, and over one hundred field locations, which includes more than 1,700 employees.

- The ADR&A Director serves as the principal advisor to the head of the organization, subject matter expert, and national spokesperson for the organization in the area of D&I, EEO/AE (including Special Emphasis Programs and reasonable accommodation), , ADR, and the civil rights programs.
- The ADR&A office is responsible for proposing and/or developing policy and responses to correspondence for the organization on all EEO/AE, ADR, D&I and CR matters, and acts as a liaison and/or spokesperson on such matters with persons and/or groups within and outside of the organization.
- The ADR&A office conducts compliance reviews, site visits, climate assessments, administrative management, and technical consulting in order to develop, review, and evaluate policies and programs impacting equal opportunity, workforce diversity, workplace inclusion (including reasonable accommodation), based on race, color, national origin, sex/gender (sexual orientation and gender identity), genetic information, age (40 and over), religion, parental status, individuals with disabilities, and protection from retaliation. The ADR&A office conducts analysis and recommends solutions to problems that impact EEO/AE, ADR, D&I, CR in establishing program priorities and direction to achieve optimum results for the organization. The ADR&A office is responsible for assembling, consolidating, and submitting timely and accurate plans, information, and reports on the organization's EEO/AE and D&I programs status. These include federally mandated plans and reports required by the Equal Employment Opportunity Commission (EEOC), the Office of Personnel Management (OPM), and White House initiatives.
- The ADR&A office administers the organizations Special Emphasis Programs (SEP) in accordance with VA policy and the VA Diversity and Inclusion Strategic Plan. ADR&A provides technical expertise and serves as the lead office in the management and operation of the organization's SEP's, ensuring they are designed to eliminate barriers to EEO and promote workforce diversity and workplace inclusion.
- The ADR&A office does not perform any Federal EEO complaints processing functions under the control and authority of ORM.

Veterans Cemetery Grants Program (40A3)

Overview

The Veterans Cemetery Grants Program complements VA's National Cemetery Administration. The program assists states, territories and federally recognized tribal governments in providing gravesites for Veterans in those areas where VA's national cemeteries cannot fully satisfy their burial needs. Grants may be used only for the purpose of establishing, expanding or improving Veterans cemeteries that are owned and operated by a state, federally recognized tribal government, or U.S. Territory. Aid can be granted only to states, federally recognized tribal governments, or U.S. Territories. VA cannot provide grants to private organizations, counties, cities or other government agencies.

VA can now provide up to 100 percent of the development cost for an approved project. For establishment of new cemeteries, VA can provide for operating equipment. VA does not provide for acquisition of land. Cemeteries established under the grant program must conform to the standards and guidelines pertaining to site selection, planning and construction prescribed by VA. Cemeteries must be operated solely for the burial of service members who die on active duty, Veterans, and their eligible spouses and dependent children. Any cemetery assisted by a VA grant must be maintained and operated according to the operational standards and measures of the National Cemetery Administration.

The administration, operation, and maintenance of a VA-supported Veterans cemetery is solely the responsibility of the state, territory or tribal government

Functions and Activities

The program assists states, territories and federally recognized tribal governments in providing burial options for Veterans in those areas where VA's national cemeteries cannot fully satisfy their burial needs. The program:

- Develops Grant application guidelines and timelines based on criteria set forth in legislation.
- Ranks and evaluates pre-applications submitted for consideration.
- Provides technical assistance to potential applicants to finalize applications.
- Develops the list of grant recommendations for the Secretary's consideration.
- Monitors expenditures/progress/deliverables to ensure proper use of grant money.

Office of the Deputy Under Secretary for Field Programs (41)

Overview

The Deputy Under Secretary for Field Programs (DUSFP) is directly responsible for the operations and maintenance of 134 national cemeteries and 33 monument/memorial sites and for all the memorial programs administered by the Department of Veterans Affairs. The DUSFP directs national cemetery operations through five district offices: North Atlantic District (Philadelphia); Southeast District (Atlanta); Midwest District (Indianapolis); Continental District (Denver); and Pacific District (Oakland). The DUSFP develops policies and procedures to administer more than 130,000 interments annually and to ensure the accurate marking of approximately 3.4 million gravesites in VA national cemeteries,

soldiers' lots and burial grounds. The DUSFP is responsible to maintain each VA cemetery as a national shrine. The DUSFP provides oversight to the Memorial Programs Service, which processes more than 365,000 requests for headstones and markers and 600,000 requests for Presidential Memorial Certificates annually.

Functions and Activities

- Establishes policies and procedures for administering the statutorily based Interment Benefit Program.
- Provides executive oversight for all programs and initiatives to ensure dignified burial and memorial services are available to eligible Servicemembers, Veterans and family members.
- Determines eligibility for burial benefits in VA national cemeteries.
- Oversees the Memorial Programs Service, which provides headstones, markers, medallions, and Presidential Memorial Certificates to eligible Veterans and family members. NCA provides these benefits for Veterans' gravesites worldwide.
- Through the Memorial Programs Service, provides executive oversight for the First Notice of Death Office, which processes notifications to prevent Compensation and Pension overpayments; and the Centralized Processing Appeals Unit, which processes Notices of Disagreement and substantive appeals submitted by applicants for burials and other memorial benefits.
- Works with USMA, the Principal Deputy Under Secretary for Memorial Affairs (PDUSMA), district offices and national cemeteries to determine appropriate policies, plans, and procedures to guide the development, operation, and administration of all national cemeteries under VA's jurisdiction.
- Oversees funding requirements/distribution for field operations components and ensures funding allocations are consistent with operations budget plans.
- Provides executive oversight of NCA district offices and national cemeteries.
- Administers the NCA emergency preparedness program, which develops and implements emergency preparedness plans and coordinates emergency responses with other VA and Federal entities nationwide.

Advises USMA and PDUSMA.

- Serves as headquarters senior official who communicates with NCA field programs concerning operational decisions impacting VA national cemeteries.
- Serves as Principal Advisor on field program issues to the USMA.
- Furnishes information and solution options on critical issues affecting current operating year activities and future plans.

- Participates with the USMA in discussions concerning policies, programs, procedures, and legislation that may affect Veterans, their families, or VSOs.
- Assesses, develops and revises policies and procedures to accommodate changing Federal requirements related to eligibility for benefits, operations, etc.
- Represents the USMA at meetings with other VA officials, Members of Congress, private enterprise, VSOs, and representatives of other Government agencies on matters pertaining to NCA.
- Represents the USMA at congressional and state briefings on topics and program activities related to NCA.
- Ensures prudent judgment by senior level program managers when exercising delegated authorities related to procurement of emergency supplies/services, specifications and policies related to headstone/marker inscriptions, and acceptance of donations made to the cemeteries and NCA's Cemetery Gift Fund.
- Oversees succession planning for key field positions and interface with VACO.

Stakeholder Engagement

- Informs Veterans, eligible family members, DoD members, VSOs, and other stakeholders about burial and memorial benefits.
- Collaborates with State and Tribal officials, DoD, National Park Service and American Battle Monuments Commission on issues of mutual concern related to the administration, operations and maintenance of Veteran and military cemeteries.
- Provides guidance and training to DoD, National Park Service and State and Tribal governments in the operations of Veteran cemeteries.
- Works with VHA on Compensated Work Therapy opportunities and annual workplace evaluations.
- Establishes agreements with VBA for assistance in determining eligibility and for other services and support; and with the National Personnel Records Center for assistance in locating military documents.

District Offices and National Cemeteries

Overview

District offices supervise the operations and maintenance of VA cemeteries organized within five regions: North Atlantic District (Philadelphia); Southeast District (Atlanta); Midwest District (Indianapolis); Continental District (Denver); and Pacific District (Oakland). District offices determine resource requirements, forecast and monitor rates of interments, support the planning to expand existing cemeteries and establish new cemeteries; administer policies related to the efficient and effective operation of VA cemeteries; and support the recruitment, development and training of

qualified employees to accomplish the NCA mission. VA national cemeteries provide burial and memorial services for eligible Servicemembers, Veterans and family members, and serve as national shrines in commemoration of those who have served.

Functions and Activities

- Provide dignified burial and memorial services for eligible Servicemembers, Veterans and family members.
- Supervise to ensure that decedents are buried in the correct gravesites and that those gravesites are properly marked.
- Monitor all aspects of national cemetery operations, evaluate procedures for effectiveness, initiate improvements, and make appropriate adjustments to accommodate changing program demands.
- Account for gravesite usage at cemeteries within the districts to ensure appropriate expansion planning
- Ensure efficient and effective operation of cemeteries by providing a management perspective on program-planning actions such as forecasted rates of interments, feasibility of new cemeteries, further development of existing cemeteries and availability of resources.
- Operate and maintain VA national cemeteries as national shrines of honor and dignity.
- Work with Office of Finance and Planning to establish operational standards and measures to quantify the levels of appearance and services required of national shrines.
- Oversee ongoing assessments of progress in achieving national shrine status.
- Determine resource requirements necessary to maintain outstanding interment and memorialization operations, and grounds, infrastructure and equipment maintenance.
- Identify significant environmental aspects associated with the operations and activities performed at VA cemeteries. Establish programs and procedures to ensure that cemetery environmental activities are conducted properly, maintaining compliance and minimizing impact to the environment.
- Manage gravesite assignment policies and operations.
- Inform Veterans, eligible family members, DoD members, VSOs, and other stakeholders about burial and memorial benefits.
- Work with NCA Human Capital Management to ensure the recruitment, selection, development and performance management of employees. Develop subordinate leaders at cemeteries and holds them accountable.
- Collaborate with NCA senior leadership and subject matter experts to ensure compliance and support for Equal Employment Opportunity principles at all levels of the organization.

- Manages use of uncompensated workforce individuals to achieve goals (e.g., volunteers, Compensated Work Therapy participants, work study students, summer youth programs, court-ordered details, and prisoners).
- Verify deceased Veterans' identify and standards of quality for burial receptacles to process reimbursement for caskets or urns for the remains of deceased Veterans who are eligible for burial and who have no known next of kin and insufficient resources to purchase a burial receptacle.
- Establish Emergency Preparedness Plans to prepare for a range of internal and external emergencies and contingency situations.
- Establish and implement comprehensive Occupational Safety and Health (OSH) programs to ensure safe and healthful working conditions for the workforce.

Office of Field Programs (41A)

Overview

The NCA Office of Field Programs develops policy and provides operational support to NCA district offices, national cemeteries and the Memorial Programs Service in the provision of VA burial and memorial benefits. This office oversees the National Cemetery Scheduling Office (St. Louis, Missouri), which provides eligibility determinations and schedules interments for all VA national cemeteries. The Office of Field Programs has responsibility to oversee the NCA Watch Officer Team in the VA Integrated Operations Center, Washington DC; and the nationwide NCA Emergency Preparedness Program. The Office of Field Programs is responsible for integrating these offices to provide timely, accurate information and documentation of key operational activities to senior leaders throughout NCA to inform decision-making and to assess operations. The Office of Field Programs is responsible for the research and development of responses to Veterans, elected representatives and other stakeholders regarding policies and programs to deliver VA burial and memorial benefits. The Office of Field Programs develops recommendations on sensitive cases involving eligibility and capital crime issues. The Office of Field Programs is responsible to research and develop recommendations to the Secretary of Veterans Affairs regarding designations of eligibility for burial in a VA national cemetery.

National Cemetery Scheduling Office (41A1)

Overview

The National Cemetery Scheduling Office (NCSO) in St. Louis, Missouri schedules committal and memorial services at VA national cemeteries located in time zones ranging from Puerto Rico to Hawaii. The NCSO establishes eligibility and arranges burials at the request of Veterans, their dependents, funeral homes, coroners, public administrators and entities such as the Missing in America Project. In addition to establishing eligibility for burial in national cemeteries, the Eligibility Division works with State and Tribal veteran cemeteries, Memorial Programs Service and with elected representatives to establish eligibility for the provision of headstones or markers in other burial locations. In 2015, NCSO established a program to accept and process applications for reimbursements associated with the purchase of a casket or urn for deceased Veterans with no next of kin and insufficient resources available for burial in a VA national cemetery. Additionally, the NCSO implemented processes to assess and determine eligibility for burial in a national cemetery prior to the time of need. This service

facilitates the planning of burial arrangements in advance of need, and provides a method for due process when a preliminary evaluation indicates a requester is not eligible for burial.

Functions and Activities

- Determines eligibility and schedules committal and memorial services at VA national cemeteries.
- Assists Veterans, their families and those acting on their behalf, to verify military service and schedule committal services and interments at VA national cemeteries.
- Accepts and processes applications for reimbursement for caskets and urns for deceased Veterans with no next of kin and insufficient resources available for burial in a VA national cemetery.
- Provide pre-need eligibility determinations for burial benefits for Veterans and their families, to facilitate planning for burial arrangements.
- Develop Memoranda of Agreements with internal and external stakeholders to assist in documenting and determining eligibility for burial and memorial benefits.

Policy, Planning and Communications (41A2)

Functions and Activities

- Liaisons to the district offices to solicit input and to disseminate and explain policy and program initiatives.
- Evaluates and develops information-based responses to process eligibility determinations for cases involving allegations of capital crimes or certain sexual offenses, and other benefit determinations such as requests to the Secretary of Veterans Affairs for Designations of Eligibility.
- Manages correspondence related to Field Programs issues between the NCA and Congressional offices, other governmental entities and individual citizens.
- Manages funding allocations for National Shrine initiatives, Maintenance and Repair projects; Non-recurring Maintenance projects, and Compensated Work Therapy program.
- Ensures homeless and indigent Veterans receive appropriate burial and memorial benefits.
- Serves as Central Office representative on high level field issue reviews.
- Coordinates with district offices and national cemeteries on national studies.
- Supports development of implementing policy and regulations following passage of new benefits legislation.

Current and Integrated Operations (41A3)

Functions and Activities

- Manages the NCA watch officer team in the VA Integrated Operations Center to collect, coordinate and analyze information about administration activities.
- Provides guidance to NCA Central Office, field facilities, and staff regarding timely and accurate flow of information to and from the VA Integrated Operations Center (VAIOC) Watch Team.
- Staffs the NCA Watch Officer position in support of the VAIOC that is responsible for collecting, analyzing, and coordinating information with VA and other Federal organizations, to include operations during contingencies and national or local emergencies.
- Implements and monitors VA policy regarding Integrated Operations Center requirements, including reporting, training, and system functions.
- Maintains communication and information exchange with NCA assets throughout the United States and with other VA and Federal operations centers such as the Department of Homeland Security (DHS) National Operations Center (NOC) and the National Response Coordination Center (NRCC) of the Federal Emergency Management Agency (FEMA) when activated.

Emergency Preparedness (41A4)

Functions and Activities

- Establishes, monitors, and administers the NCA nationwide emergency preparedness program to ensure site-specific risks and hazards affecting national cemeteries and office locations are adequately addressed.
- Develops, implements and maintains emergency preparedness plans, policies, and procedures with the goal of reducing injury and loss of life or property within NCA as a result of an emergency or disaster.
- Coordinates emergency response training and exercises for all NCA offices and personnel, district offices, national cemeteries and other field sites throughout the United States (U.S.) and U.S. Territories.

Memorial Programs Service (41B)

Overview

Memorial Programs Service (MPS) administers all policies and programs for the provision of Government-furnished headstones, markers, and medallions. MPS operates satellite offices in Nashville, TN and Fort Leavenworth, KS. Additionally, a supervisor at Abraham Lincoln National Cemetery, IL oversees individual employees stationed at VA facilities throughout the nation. These satellite offices and remote employees process routine applications for headstones, markers, and medallions. The Applicant Assistance Unit in Washington, D.C. consists of a call center and staff which provides eligibility assistance, resolves issues, and processes headstone and marker replacement requests. MPS manages the Presidential Memorial Certificate program in Washington, D.C., which

honors the memory of honorably discharged, deceased Veterans. MPS provides oversight for two operations in St. Louis, Missouri: the First Notice of Death Office, which processes notifications to prevent Compensation and Pension overpayments; and the Centralized Processing Appeals Unit, which processes Notices of Disagreement submitted by applicants.

Operations (41B1)

- Provides oversight for policy development, service provision and contracts related to the Federal headstone, marker and medallion program; the Presidential Memorial Certificate program; the First Notice of Death Office and the Centralized Appeals Processing Unit.
- Reviews and determines appropriate action on requests to make new Emblems of Belief (EOB) available for inscription on Government-furnished headstones and markers. An EOB is an emblem or symbol that represents the sincerely held belief of the decedent during his or her life that constituted a religion or the functional equivalent of religion.

Program Support Unit (41B2)

- Arranges for the manufacture and delivery of headstones, markers, and medallions to eligible recipients, and ensures appropriate quality control of products.

Presidential Memorial Certificates Program (41B3)

- Through the Presidential Memorial Certificate (PMC) Program, NCA provides next of kin and loved ones with an engraved paper certificate signed by the current President to honor the memory of honorably discharged, deceased Veterans. NCA staff determines eligibility and oversees the production, inspection, and delivery of PMCs to eligible recipients.

Applicant Assistance Unit (41B4)

- Operates the national customer call center operations to provide direct customer service for inquiries related to headstone, marker, and medallion benefits.

Centralized Processing Appeals Unit (41B5)

- Reviews Notices of Disagreements regarding denied burial and headstone and marker claims and prepares appeals packets for processing to the Board of Veterans' Appeals.

MPS Processing Sites (41B6, 41B7, 41B8)

- Determine eligibility and process requests for Government-furnished headstones, markers and medallions.

First Notice of Death Office (41B9)

- Updates electronic files to ensure timely termination of benefits and next-of-kin notification of possible entitlement to survivor benefits. In 2009, NCA assumed responsibility of VA's First Notice of Death Program, previously administered by the VBA.

Cemetery Development and Improvement Service (41C)

Overview

Cemetery Development and Improvement Service (CDIS) is based in Indianapolis, IN with technical staff assigned at district offices and national cemeteries across the United States. CDIS provides leadership, coordination and direction for NCA real property land issues, and integrates cemetery operational requirements into major and minor construction project designs. CDIS provides technical and engineering guidance for cemetery operations, GPS/GIS national program initiatives; fleet vehicle and equipment program requirements; and research/development of new processes and technologies to improve national cemetery operations.

Functions and Activities

- Recommends and coordinates acquisition of new sites for future VA national cemeteries and the expansion of existing cemeteries based on evaluation of site locations, Veteran population, topography, access to property, historical and cultural significance of sites, and the potential for gravesite yield.
- Provides technical review and guidance on all national cemetery project and operational issues, including the specific areas of pre-placed crypts; columbaria; fleet vehicles and equipment; and irrigation systems.
- Accomplishes technical design reviews for all NCA major and minor projects to ensure organizational consistency and compliance with established national shrine quality and functional requirements.
- Manages and oversees the research, development and design of new products, processes and procedures to improve burial operations and equipment for the future.
- Manages and implements national program initiatives for the use of GPS/GIS technologies to permanently document cemetery and burial site features.

Office of the Deputy Under Secretary for Finance and Planning/CFO (42)

Overview

The Deputy Under Secretary for Finance and Planning/Chief Financial Officer directs and provides leadership for a broad range of management activities, including: budget and financial operations, strategic planning, performance management and reporting, demographic analyses, management and decision support, business and customer service process improvements, internal controls, program evaluations, Veterans Cemetery Grants Compliance and legislative and regulatory actions. As NCA's Chief Financial Officer, contributes to the overall improvement of financial management throughout the Department.

Functions and Activities

Policy and Planning

- Plans and directs nationwide demonstration programs for managing and improving service delivery, including future projections and management practices, organizational modifications, resource utilization and communication networks.
- Oversees organizational analyses, studies, and reviews within NCA in support of strategic and business plans.
- Manages development of strategies and performance measures NCA will employ to achieve its goals and objectives.
- Demographic analysis to develop recurring and special statistical and management reports covering all facets of NCA unique operations.

Budget Formulation/Execution

- Responsible for capital and performance budgeting.
- Budget execution.
- Formulates, justifies, and monitors budget requirements, funding, obligations, and expenditures for all NCA programs.
- Oversees NCA's nationwide managerial cost accounting function.

Financial Operations/Accountability

- Oversees the management of Government wide card programs (purchase cards, fleet cards, etc.) for staff at all levels and all NCA locations.
- Provides agent cashier functions for NCA field offices that include the deposit and proper accounting of official and unofficial funds for all NCA appropriations.
- Leads the management of financial aspects of NCA's real property.
- Analyzes and applies NCA-specific internal controls and data on improper payments, financial statements and Government purchase cards.

Business Process Improvement and Compliance

- Leadership responsibilities for internal controls and reporting.
- Oversees the NCA Organizational Assessment and Improvement (OAI) Program for national cemeteries and Central Office components.
- Promotes special projects related to the strategic goals of NCA.

Congressional relations and legislative and regulatory development:

- Ensures that NCA regulatory analysis, development, and review actions meet the regulatory and rule-making requirements.
- Oversees establishment and maintenance of NCA's formal policy/procedures publications program.
- Coordinates the review and analysis of proposed and final legislation related to burial and memorialization, provide NCA views on proposed to OCLA staff for response to Congress; provides technical assistance to VA/congressional members as required.

Policy and Planning Service (42A)

Overview

The Policy and Planning Service is responsible for NCA-level long range planning and performance analysis and reporting efforts. This Service coordinates all long range planning efforts for the Administration and supports both NCA Central Office and field units by providing workload and performance data analysis that is critical for informed decision making. The Policy and Planning Service is also responsible for developing policies that expand and enhance access to a burial option for US Veterans who reside within the United States, Puerto Rico, and US Island Areas. The Service supports such policy development through Veteran population analyses that identify the present and future locations of Veterans and identifies gaps in providing Veterans with reasonable access to a burial option.

Functions and Activities

- Conducts organizational analyses, studies, and reviews within NCA to develop operational plans that affect the future needs of the Administration.
- Initiates studies and develops plans to meet future needs of NCA, and those whom we serve.
- Ensures implementation of the Government Performance and Results Act Modernization Act requirements, including managing long range and tactical planning processes that set forth the future direction of NCA.
- Consults with all elements of NCA to develop NCA strategic goals and objectives.
- Consults with other external stakeholders that have a vested interest in NCA programs, such as OMB, congressional committees, state Government officials and VSOs.
- Works with planning officials throughout the Department and other executive branch agencies to ensure NCA strategic and tactical business plans are integrated with the plans of the SECVA and outside entities.
- Determines the strategies and performance measures NCA will employ to achieve its goals and objectives to measure success.

- Defines the data needed to evaluate the effectiveness of NCA programs and directs NCA efforts to capture and report needed data utilizing automated information systems and customer survey instruments.
- Ensures NCA leadership has current, valid, and relevant client satisfaction data for all major benefits and programs that NCA delivers. Collects and maintains all client/customer and employee satisfaction data. Plans, develops, and executes strategies to improve client/customer and employee satisfaction with NCA products and services.
- Plans, develops, and promotes new policies that improve or enhance the completion of the NCA mission, and supports efforts for implementation throughout NCA.
- Conducts statistical research to develop demographic characteristics of Veterans and their dependents to serve as the basis for recommendations for optimum locations of proposed national cemeteries.
- Directs, develops, and produces recurring and special statistical and management reports covering all facets of NCA unique operations to include analyses of interment activities, gravesite usage, acreage usage and other cemetery performance data.
- Serves as the Systems Administrator for the NCA Management Decision and Support System that ensures the accuracy and integrity of workload and performance information.
- Identifies the need for and directs the accomplishment of special studies and investigations that report on the status and effectiveness of burial and memorial benefits and services provided by NCA, the impact of external public and private activities and conditions on burial and memorial services and benefits, and the effect of burial and memorial services and benefits on other Federal, state and local activities.

Budget Service (42B)

Overview

Budget Service manages the planning, programming, formulation, preparation, execution, and reporting of NCA's budget and nationwide oversight of budget activities. This includes the development and analysis of budget estimates for all accounts and the development of NCA policy and procedures concerning all budget formulation and execution activities.

Functions and Activities

- Programs, formulates, justifies, and monitors budget requirements, funding, obligations, and expenditures for all NCA programs, including unique requirements related to cemetery operations and maintenance, major and minor cemetery construction projects, capital asset investment, historic properties, grants to states and tribal organizations to establish and maintain Veterans cemeteries, multiple burial benefits as established by Congress (interment, grave liners, outer burial receptacles, headstones, markers, and medallions), the NCA Gift Fund, and the NCA Facilities Operation Fund.
- Serves as liaison to Department Office of Management on budget matters and requests from the Senate and House Appropriations Committee staffers and OMB.

- Provides cost estimate on all proposed legislation affecting burial benefits.
- Monitors NCA's capital asset investment budget and plan, which includes construction and maintenance repair projects at the national cemeteries.
- Monitors obligations, prepares Monthly Performance Reviews (actuals to operating plans), enables reallocation of resources to achieve program mission.
- Provides guidance to Central Office and Field operations on appropriate funding levels, purchases, travel policy, authorizations, and vouchers. Tracks and executes funding in support of Service Level Agreements, Interagency Agreements, and Memorandums of Understanding.
- Ensures funding justification materials and execution of funds is in compliance with OMB Circular A-11 *Preparation, Submission, and Execution of the Budget*
- Analyzes, develops, and justifies cemetery expansions and the asset repairs and improvements portion of the VA construction budget.
- Manages NCA's review of facility condition assessments.
- Provides NCA-specific data for the VA construction budget related to cemetery expansions and asset repairs and improvements.
- Oversees NCA's nationwide managerial cost accounting function.

Finance Service (42C)

Overview

Finance Service conducts centralized accounting and financial accountability functions for NCA's 134 national cemeteries. Responsible for administering good financial stewardship of accounting operations, internal controls, audit reviews, financial policy and reporting, financial statements, and oversees the administration's purchase card program.

Functions and Activities

- Oversees and manages Government wide card programs (purchase cards, fleet cards, etc.) for staff at all levels and all NCA locations by determining appropriate policy, administration, and audit activities to meet facility-specific needs.
- Provides agent cashier functions for NCA field offices that include the deposit and proper accounting of official and unofficial funds for all NCA appropriations, including the NCA Operations and Maintenance Fund and the Agriculture Lease Fund.
- Monitors NCA's Accounts Receivables for employee debts and works in consort with the VA Finance Services Center for recording and collection of Vendor Receivables and Employee payroll related debts. Monitors NCA's Account Payables for undelivered orders and works in consort with VA Finance Services Center for invoice payments.
- Monitors unapplied deposits and/or suspense accounts for proper recording of transactions.

- Oversees NCA Cemetery Gift Fund activities, including accepting and spending donated funds and materials. This fund was established in 1989 as a trust fund financed from gifts and bequests from donors.
- Serves as the NCA liaison with the OIG and the Independent Financial Statement Auditors for all financial matters related to NCA audits, and develops NCA-specific remediation activities as necessary.
- Manages and monitors user access and permissions for all NCA-specific transactions in the Centralized Administrative Accounting Transaction System (CAATS).
- Analyzes and applies NCA-specific internal controls and data on improper payments, financial statements and Government purchase cards.
- Manages the financial aspects of NCA's real property, including financial oversight of construction projects, works in process, asset capitalization, and any financial reporting of deferred maintenance and environmental liabilities.
- Provides formal NCA-specific training program for field staff with financial responsibilities at the NCA Training Center or via distance learning. Develops and maintains NCA-specific financial management systems unique to cemetery operations and memorial benefits. Determines system specifications and software requirements to ensure interconnectivity with the Department's core accounting system and compliance with Federal financial standards.

Business Process Improvement and Compliance Service (42D)

Overview

The Service conducts multiple types of reviews to assess conformance to standards, identifies areas of potential improvement, and leads various improvement initiatives. As a basis for reviews, the Service also ensures that national cemeteries, and Veterans cemeteries receiving grants, have a current version of Operational Standards and Measures, and all cemeteries have current internal controls requirements for the Annual Statement of Assurance. Other key activities include: administration of the Annual Statement of Assurance process, Baldrige-based management assessments, and liaison responsibility for NCA with GAO, OIG, and the National Quality Council.

Functions and Activities

- Conducts regular evaluations of NCA's internal controls systems and provides reports, findings, and recommendations to NCA's CFO.
- Reports, internal audits, and internal abatement plans are conducted to ensure compliance with the Federal Managers Financial Integrity Act.
- Serves as the NCA subject matter expert and liaison with the OIG and the GAO to determine appropriate NCA actions for all matters related to studies, audits, and investigations involving NCA programs and functions, and ensures that NCA action plans and other required follow-on actions are completed and reported in a timely manner.

- Conducts Veterans Cemetery Grants compliance reviews to ensure cemeteries receiving grants maintain grounds and service to NCA standards. Compliance reviews identify areas of strength and opportunity. Cemeteries considered provisionally compliant are required to submit an action plan and report on progress.
- Manages the NCA Organizational Assessment and Improvement (OAI) Program for national cemeteries and Central Office components. This program integrates Baldrige Performance Excellence Framework, Internal Controls, Performance Scorecards, and other key program areas to form a comprehensive organizational review and improvement system for NCA.
- Plans, develops, and maintains procedures and systems for assessing the effectiveness of operational and business practices throughout NCA Central Office, Districts, and VA national cemeteries.
- Leads Lean Six Sigma and other types of improvement, redesign, and evaluation projects to improve organizational effectiveness. Develops, implements, and evaluates programs to prevent and correct unsatisfactory conditions and elements that influence the regulatory correctness and responsiveness of transactions and services.

Legislative and Regulatory Service (42E)

Overview

NCA's Legislative and Regulatory Service ensures that NCA has and maintains the legislative and regulatory **Authorities** for providing burial and memorialization benefits; maintains effective relationships with Congress; develops and publishes necessary policy documents to inform the public and NCA staff of programmatic and operational decisions; and obtains necessary guidance from the Office of General Counsel in support of NCA's leadership and management.

Functions and Activities

- Ensures that NCA's regulations are developed and revised in accordance with the Administrative Procedure Act, reflect or interpret statutory authorities, and provide information sufficient to alert the public of the benefits offered by NCA and processes to obtain those benefits.
- Establishes and maintains NCA's formal policy/procedures publications program that supports all NCA offices/programs by identifying the need for and developing nationwide policy and procedural guidance.
- Advises NCA senior executives on all congressional and legislative issues.
- Coordinates the review and analysis of proposed and final legislation related to burial and memorialization, provide NCA views on proposed to OCLA staff for response to Congress; provides technical assistance to VA/congressional members as required.
- Coordinates responses to inquiries from congressional staff and committees with NCA and OCLA staff; coordinates and tracks Congressionally-mandated reports.
- Coordinates all NCA briefings or meetings to congressional staff and members, including preparation of staff for testimony on burial benefits and related matters before Congress and

briefings to congressional members and staff. Develops legislative proposals related to NCA provision of burial benefits; coordinates through VA and OMB; tracks proposal status.

- Serves as NCA liaison with the VA Office of General Counsel, provides subject matter expertise and coordinates research, review, and action/advice on all legal issues related to national cemetery operations and memorial and burial benefits for Veterans and dependents.
- Update and inform NCA staff of relevant changes to statutory or regulatory authorities.

Office of the Deputy Under Secretary for Management (43)

Overview

The mission of the Office of Management is to streamline the operations of NCA for greater efficiency and effectiveness. By integrating contracting, project management, site design, human capital, communication, and the NCA history program, the Office is able to personalize and enhance the quality of its service to internal and external customers.

Functions and Activities

Human Capital Management

- Oversees and administers all human resources life cycle management for NCA, including staffing and recruitment, classification, training and workforce planning, special programs, policy and guidance, labor and employee relations, safety and health.

NCA Executive Correspondence

- Serves as primary point of contact with VA's Office of the Executive Secretariat on matters concerning executive correspondence management.
- Reviews, prepares documentation and tracks all administration correspondence, IRIS inquiries and Veteran Cemetery Grants.

NCA Communications and Outreach Support

- Provides expert public affairs and communications advice and support to the Under Secretary for Memorial Affairs, senior staff, district directors and cemetery directors. Serves as the primary point of contact with VA's Office of Public Affairs.
- Manages VA's Advisory Committee on Cemeteries and Memorials
- Manages the NCA Strategic Communication Council
- Conducts memorial benefit and national cemetery awareness outreach programs and events
- Oversees official statements, fact sheets and publications.
- Provides content for NCA websites.

- Maintains NCA's social media sites.

History Program

- Undertakes and oversees historical research about the Administration and its properties dating to the Civil War and before, cemetery features, cultural resources, policies, burial benefits, and people.
- Plans and manages historic preservation documentation and conservation projects.

Design and Construction

- Oversees and collaborates on cemetery design and construction for all phases and aspects of minor construction and expansion projects in NCA.
- Oversees strategic efforts for systematic expansion of national cemeteries and interment space for eligible Veterans and family members.

Contracting

- Administers supply, acquisition, and contracting activities in compliance with Federal and VA acquisition regulations to meet the unique needs of NCA's national cemeteries, Districts, and headquarters elements.
- Assures SECVA's goals are met in regard to small and Veteran-owned businesses.
- IT Business Requirements and Administrative Service oversees development and sustainment of systems necessary to support NCA specific programs and missions while providing technical advice and guidance on new data management systems for future needs.
- Oversees the program that ensures NCA management and staff in all locations plan for and comply with federal and VA requirements, policies and procedures concerning records management and access to records under the Freedom of Information and Privacy Acts.
- Oversees space management and property to ensure that all NCA Central Office employees' office needs are met.

Memorial Benefits Management System (MBMS) Program Management Office (PMO)

- Oversees the management of new business and technology projects.
- Manages business operational design of new programs for business information systems.
- Oversees delivery of value and transformation of information systems for the NCA mission and goals.

Management and Communication Service (43A)

Executive Correspondence (43A1)

Overview

The Executive Correspondence Division is comprised of one Supervisory Program Analyst, four Correspondence Analysts, and two Program Specialists. The Division oversees the management of all correspondence for the National Cemetery Administration (NCA).

Functions and Activities

- Serves as NCA's primary point of contact for all correspondence pertaining to the administration. Works closely with VA's Office of the Executive Secretariat and other administration and staff offices on matters concerning executive correspondence management.
- Develops and implements policy and procedures for the Central Office and various facilities around the country (e.g., Districts, Memorial Processing Sites and national cemeteries) concerning standards, timeliness, and processing of correspondence.
- Provides training and assistance to NCA staff on the use and functions of VA's correspondence tracking system.

Communications and Outreach Support (43A2)

Overview

Provides expert public affairs and communications advice and support to the Under Secretary for Memorial Affairs, senior staff, district directors and cemetery directors. Serves as the primary point of contact with VA's Office of Public Affairs.

Functions and Activities

- Oversees the writing of official statements, press releases, articles, biographies, fact sheets, and other materials for NCA.
- Plans major NCA special ceremonies and activities, such as dedications and groundbreaking ceremonies for the opening of new national cemeteries.
- Manages activities of the VA Advisory Committee on Cemeteries and Memorials, such as arranging meetings and presentations, and coordinating the Administration response to Committee recommendations.
- Submits NCA portion of the Weekly Cabinet Report for White House Staff review.
- Develops outreach training programs, materials, and displays for presentation at national and regional Funeral Directors' conferences, VSO conferences, and various other stakeholder conferences and meetings.
- Maintains NCA website content and social media sites, and monitors pertinent news outlets.

History Program (43A3)

Overview

The History Program function, initiated in 2001, is currently composed of three permanent staff who meet the Secretary of the Interiors' professional qualifications for history and historic preservation. Diverse activities and responsibilities intersect with those of all NCA Services and offices located system wide.

Functions and Activities

- Undertakes and oversees historical research about the Administration, and its properties dating to the Civil War and earlier, cultural resources, policies, and burial benefits in response to inquiries from NCA, VA, other Government offices, and the public; develops special commemorative programs for VACO, NCA localities and the public.
- Serves as the subject matter expert in verifying historic information in support of NCA-administrated benefits.
- Develops or reviews content of correspondence, technical studies, exhibits, interpretive signage, and outreach related to the history of NCA and its predecessors; initiates documentation projects about historic resources, including National Register of Historic Places nominations per Section 110 and Section 112 of the National Historic Preservation Act of 1966 (NHPA).
- Maintains the NCA History Collection encompassing textual records, ephemera, a library, architectural, and grave marking artifacts, maps/drawings, photographs and electronic media; assures collection contents are properly documented, secured and organized; and develops artifact loan agreements as part of mitigation and educational efforts.
- Plans and manages conservation projects requiring specialized preservation treatments serving as Contracting Officer's Technical Representative; supports other NCA offices meeting preservation requirements per Section 106, NHPA; provides NCA historic preservation accomplishments and activities to the VA Federal Preservation Officer for departmental reporting.
- Produces oral history interviews of senior leadership, long-time employees and other persons of interest whose personal recollections of NCA activities and decision-making serves to complement and enhance the written Administration records.
- Designs and provides training to all levels of NCA about the origins of national cemeteries, monuments, grave marking, and individual Veterans, as well as how to identify and preserve historic resources in the cemeteries.
- Advises on Capital Asset Inventory (CAI), Facilities Condition Assessment (FCA), and BOSS content for historic resources including monuments, headstones and markers; tracks new donated monuments and oversees annual verification; advises on content of proposed new NCA monuments. Produces and reviews history content for NCA website; reviews and verifies content for Notable Burials.

Design and Construction Service (43B)

Overview

The Design and Construction Service provides comprehensive project management of NCA's Minor Construction program. The service provides oversight, guidance and policy on construction standards and engineering/facility management activities. The service also develops future engineering/facility requirements/programs/projects.

Functions and Activities

- Oversees and collaborates on cemetery design and construction for all phases and aspects of minor construction and expansion projects in NCA. Authorizes release of funds and increases or adjusts funds based on project deliverables. Negotiates on behalf of VA/NCA in generating proposals regarding land planning, construction of new cemeteries, and the expansion and improvement of established national cemeteries.
- Oversees strategic efforts for systematic expansion of national cemeteries and interment space for eligible Veterans and family members.
- Advises NCA senior executives on utilization of appropriate methods to resolve construction-related issues.
- Serves as a technical resource in developing criteria to the Veterans Cemetery Grants Program and in the establishment, development, and expansion of State and Tribal Veterans cemeteries.
- Forecasts planning efforts in land acquisitions, fund allocation, construction estimates, project justifications, design and construction activities, and environmental compliance.
- Manages and monitors projects related to the construction program; issues delegation authorities for all minor construction projects.
- Provides technical review and guidance on national cemetery project and operational issues, including the specific areas of pre-placed crypts, columbaria, and national agronomy concerns.
- Conducts studies and develops operational plans in anticipation of future expansion and construction needs of NCA. Supports NCA strategic planning processes by analyzing plans in order to accomplish construction management requirements.
- Develops and evaluates annual minor construction operating plans, and establishes and monitors milestones and monthly obligation budget target compliance. Supports the capital investment proposal process required for NCA construction in support of the annual VA planning and budget submissions.

Contracting Service (43C)

Overview

Contracting Service provides real time procurement support throughout the NCA with a goal of securing supplies, services, and construction projects at a fair and reasonable price. The service provides

guidance in accordance to the Federal Acquisition Regulations, Veterans Affairs Acquisition Regulations, and policies to ensure project coordination plus service delivery on a timely basis to the customer.

Functions and Activities

- Administers supply, acquisitions, services, construction, Architectural and Engineering services and contracting activities in compliance with Federal and VA acquisition regulations to meet the unique needs of NCA's national cemeteries, Districts, and headquarters elements. Analyzes and evaluates markets for unique supplies and services needed to meet NCA operational needs (such as grounds maintenance for cemeteries that are several hundred acres in size, outer burial receptacles or crypts, headstones, markers, and medallions production and delivery), develops procurement sources, and maintains relations with vendors. Advises NCA staff on planning, developing, and implementing statements of work, specifications, and strategies for standardization of items used at multiple locations and consolidated buys.
- Coordinates implementation of legislation and executive orders affecting national cemetery operations related to energy conservation, recycling, "greening the Government" and related initiatives to ensure full NCA compliance.
- Assures SECVA's goals are met in regard to small and Veteran-owned businesses.

Information Management and Business Support Service (43D)

Overview

NCA's Information Management and Business Support Service is responsible for NCA Freedom of Information Act (FOIA), Records Managements, Publications and Privacy Act (PA) Programs and are compliant in all NCA locations throughout the country; provides space management, property accountability, and information technology equipment support for the NCA Central Office (NCACO); and provides liaison and troubleshooting support to NCA field sites on property accountability and information technology equipment issues.

Functions and Activities

- Ensures NCA complies with federal and VA requirements, policies and procedures concerning access to records under the Freedom of Information and Privacy Acts.
- Ensures all records management and official forms are compliant with OMB and Paperwork Reduction Act standards.
- Manages printing contracts and publications for NCA.
- Ensures all NCA Central Office employees' space management and property management needs are met.
- Maintains all copier contracts within NCACO.
- Oversees all major space renovations within NCACO to include space design, purchase of furniture, identifying swing space and movement of offices to and from swing space.
- Provides guidance to NCA field offices on space management, renovations, and moves.

- Serves as a liaison between field sites and Austin Information Technology Center (ATIC) on all Tier II IT equipment issues including finance and budget planning for that equipment to ensure that NCA needs are communicated and funded.
- Provides guidance to all NCA field locations on maintaining accountability on the IT and non-IT equipment.
- Processes reasonable accommodations requests for furniture and IT equipment solutions within NCACO. Provide advice to field locations on the development of such solutions at field locations.
- Provides oversight and support to ensure NCA employees have most appropriate IT equipment and Tier II help desk tickets are resolved in a timely fashion.
- Ensures NCA complies with federal and VA requirements, policies and procedures concerning HSPD-12.

Business Transformation, Sustainment and Requirements Service (43E)

Overview

The Business Transformation, Sustainment and Requirements Service (BTSRS) supports the transformation of the National Cemetery Administration (NCA) by modernizing the NCA wide IT applications capabilities. BTSRS will address data weaknesses, expand end-user functionality (e.g. chain of custody tracking, Veteran case status, digital mapping, gravesite validation, online forms, etc.), re-architect to enable integration with enterprise services. Ultimately this will increase NCA employee and customer satisfaction in support of Veterans and their families. BTSRS will lead the design, development, and deployment of the modernized architecture, while supporting the legacy requirements with the focus on reducing risk and optimizing resources.

Functions and Activities

- Organizes the MBMS program to ensure business outcomes & value delivery.
- Ensures the delivery of short term enhancements to the current business and web platforms.
- Stands up plans, approach and design for the long term platform replacement.
- Represents NCA business leadership and their needs in dealings with Office Information and Technology (OIT).
- Ensures the MBMS solutions are designed and deployed in accordance with the Voice of the Business.
- Ensures a timely and cost effective solution to meet the needs of the business.
- Manages partners for delivery of the overall Program within the constraints of scope, time, and budget..
- Collaborates with the strategic planning process to define the business vision and goals.

- Engages with the PPBE process to ensure that funding and budgets are sized to delivery against the strategic goals.
- Advises and provides technical guidance to NCA senior management and other federal and state agencies, Arlington National Cemetery, and various State Veterans' cemeteries on new data management systems.
- Engages with VA wide initiatives and Enterprise Architecture activities to ensure that enterprise models include NCA needs, and that EA artifacts include NCA inputs.
- Provides business architecture guidance and management to NCA in order to align the technology to its customers, people and mission.
- Leads business process re-engineering design and requirements.

Human Capital Management (43F)

Overview

Human Capital Management is responsible for all human resource products, services, and activities in NCA, including staffing and recruitment, classification, training and workforce planning, special programs, policy and guidance, labor and employee relations, safety and health.

Functions and Activities

- Delivers strategically aligned customer-focused human resources (HR) products and services to the NCA workforce.
- Administers and manages all delegated human resource authorities, including activities associated with NCA-unique employment requirements affecting recruitment and placement; position classification and management; employee and labor relations; employee benefits administration; and safety and health.

Training, Workforce Development, and Safety (43F1)

Overview

The Training, Workforce Development, and Safety division is responsible for leading and/or coordinating all training and development activities for NCA employees. It also provides workforce planning and safety expertise to NCA in support of CO and field operations.

Functions and Activities

- Operates a NCA-specific training program that encompasses all activities performed by NCA staff in locations nationwide, including job functions ranging from manual and/or skilled physical labor to financial management to labor relations to performance and analysis functions.
- Manages NCA's leader development program, partnering with VALU and other organizations to ensure that NCA's current and future leaders are positioned for success.

- Oversees operation of the NCA National Training Center in St. Louis, MO, and through the NCA Director, Training, Workforce Development and Safety, provides NCA-specific and commercially unavailable technical and leadership training for Cemetery Director Interns, Cemetery Directors, and other field and central office personnel, to develop competency and reinforce uniform operating procedures and standards.
- Manages NCA's Cemetery Caretaker Apprenticeship Program (CemCAP) for homeless Veterans.
- Provides workforce planning support to NCA leadership, staff, and field units, in the form of expertise and advice on staffing levels, position management, competency development, and succession planning.
- Manages and oversees the NCA Occupational Safety and Health program, designed to meet the specific safety and health needs of staff administrative functions performed in office environments, and staff field functions performed during typical cemetery operations, such as grounds maintenance, burial activities and headstone or marker installation.
- Manages and oversees the NCA Office of Workers Compensation Program (OWCP).

Human Capital Management, Policy and Programs (43F2)

Overview

The Policy and Programs Division is responsible for developing policies, plans, and programs that provide guidance and inform NCA managers and employees on human capital management areas such as recruitment and hiring, performance management, employee benefits, employee engagement, employee and labor relations, telework, safety and other workplace matters.

Functions and Activities

- Provides advisory services, training, and support to NCA leaders and managers to enhance their efforts to effectively manage the National Cemetery Administration.
- Designs and implements strategies, policies and programs which address human capital management initiatives and requirements and foster high ethical standards in achieving NCA's strategic goals.
- Leads efforts to design and fully utilize performance management systems to effectively communicate performance expectations and help achieve organizational goals.
- Develops and delivers well designed business practices and tools which support employees and encourage their full engagement and participation in efforts to deliver exceptional service to America's Veterans.
- Administers and manages the Goals Engagement Accountability Results (GEAR) program for NCA.

Human Resources Center – Indianapolis, IN (43F3)

Overview

The NCA Human Resources Center (HRC), located in Indianapolis, IN, is responsible for all HR operations and processing for NCA. The HRC administers the delegated HR **Authorities** of the USMA.

Functions and Activities

- Responsible for providing advisory assistance, forms processing, regulatory interpretation, and personnel transaction coding for NCA employees and managers within all areas of HR, to include recruitment and placement; position classification and management; employee and labor relations; and employee benefits administration.
- Provides expert advisory opinions to NCA management in all areas of HR.
- Monitors, evaluates, and meets NCA obligations to report on HR performance metrics in order to identify trends, address process issues, and improve the HR process within NCA.

Office of Management

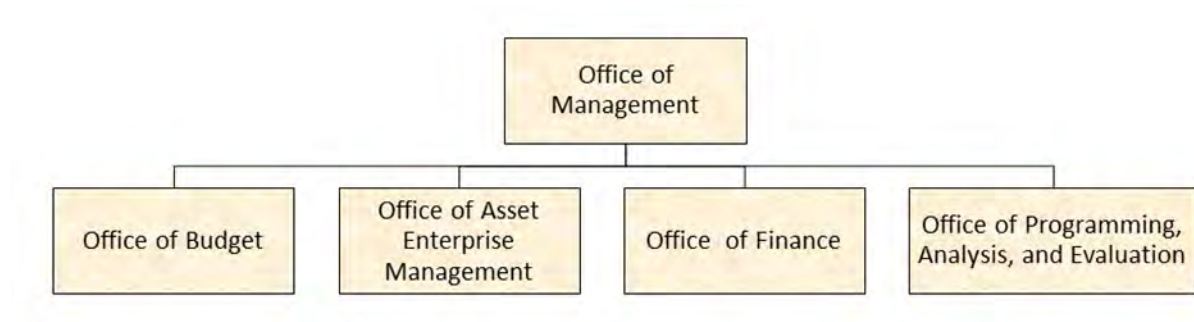


Figure 14 - Office of Management Organization Chart

[Click here for the alternate representation of the chart](#)

Mission

The Office of Management (OM) enables VA to provide a full range of benefits and services to our nation's Veterans by providing strategic and operational leadership in budget, financial management, programming, cost analysis, and asset enterprise management. It also promotes public confidence in the Department through stewardship and oversight of business activities that are consistent with national policy, law, and regulation.

Office of the Assistant Secretary for Management and Chief Financial Officer

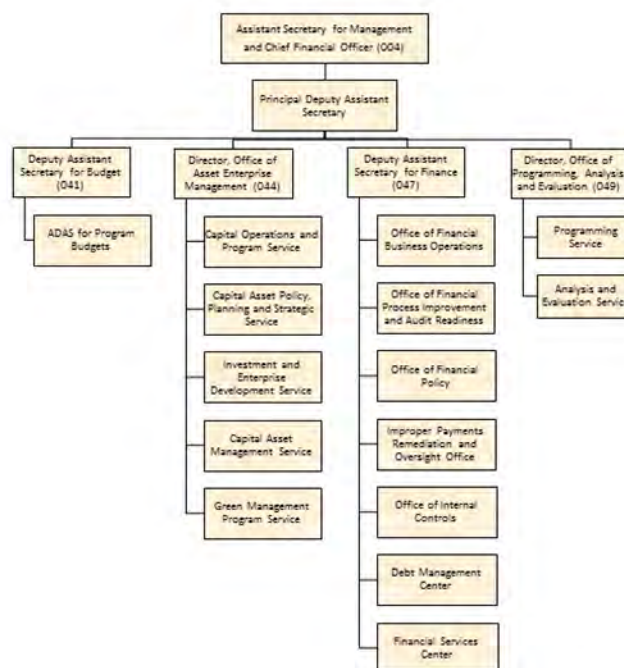


Figure 15 - Office of the Assistant Secretary For Management[Click here for the alternate representation of the chart](#)**Overview**

OM supports the Administrations and Staff Offices through four major service lines and has a number of activities and initiatives underway to help improve the Department's operations.

Functions and Activities

- The Assistant Secretary for Management oversees all resource requirements, Budget formulation, and financial management activities relating to VA programs and operations. In addition, responsibilities include a Departmental accounting and financial management system that provides for management, cost, and account information. OM also oversees the Department's capital asset management activities and business oversight activities, including development and implementation of policies and regulations.

*Office of the Assistant Secretary for Management***Overview**

The Assistant Secretary for Management and Chief Financial Officer oversees all resource requirements, development and implementation of agency performance measures, and financial management activities relating to VA programs and operations. In addition, responsibilities include a Departmental accounting and financial management system that provides for management, cost, budgeting, and account information. In addition, OM oversees the Department's capital asset management activities and business oversight activities, including development and implementation of policies and regulations.

Office of Budget

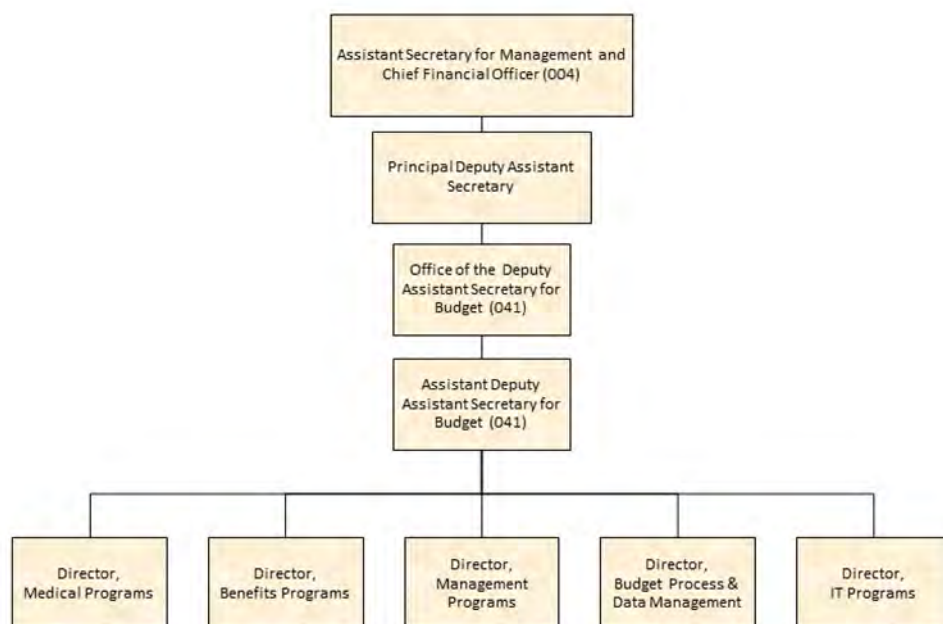


Figure 16 - Office of Budget Organization Chart

[Click here for the alternate representation of the chart](#)

Overview

The Office of Budget supports the Department in service to Veterans by managing the strategic and policy decision making processes in the formulation, execution, analysis, justification, and preparation of the Department's budget. The office serves as the primary liaison with the Office of Management and Budget (OMB) and Congressional appropriations committees to defend and promote the Department's program plans and budget estimates. The office also coordinates closely with program officials to ensure budget requests are technically accurate, performance-based, and focused on improving the Veteran experience.

Functions and Activities

The Office of Budget manages and directs all budget formulation and execution activities for the Department.

- Ensures all funds are spent in compliance with laws, guidance, and directives from OMB and Congress, as well as Departmental policies and plans.
- Leads budget execution review processes and keeps VA leadership informed of key issues and trends.
- Issues guidance to VA Administrations and Staff Offices to prepare, review, and analyze their internal budgets/operating plans, and develop analyses, options, and recommendations for budget decision-making.

- Manages all aspects of VA's annual budget request to OMB to defend and promote the Department's program plans and budget estimates, and negotiates/appeals the OMB Passback decisions.
- In coordination with Administrations and Staff Offices, develops Congressional Justifications Budget and the data for the President's Budget Appendix.
- Manages monthly CFO budget execution reviews.
- Represents VA in budget deliberations with OMB and Congressional appropriations committees.
- Develops testimony, briefing books, and materials for Department leadership's budget presentations to Congress, VSOs, and the media.
- Manages Questions for the Record, Congressional Tracking Reports, and other inquiries from the House and Senate Appropriations Committees.

Authorities

OMB Circular A-11

OMB Circular A-19

OMB Circular A-129

Title 31

31 U.S.C. 1341 et seq.

P.L. 112-74

GAO Red Book

The Economy Act and the Account Adjustments Statute

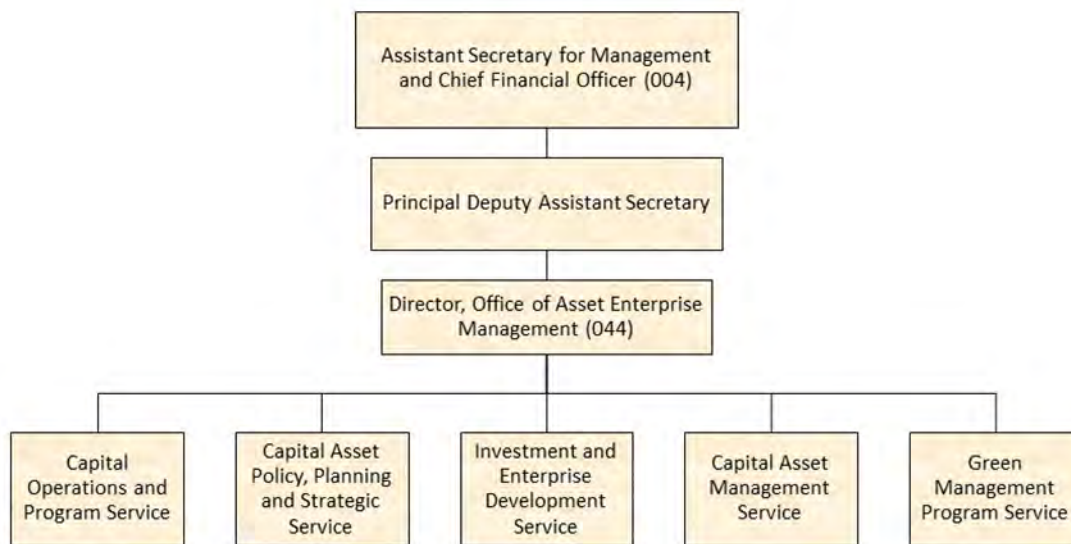


Figure 17 - Office of Management - Office of Asset Enterprise Management

[Click here for the alternate representation of the chart](#)

Office of Asset Enterprise Management

Overview

The Office of Asset Enterprise Management (OAEM) provides the Assistant Secretary for Management/Chief Financial Officer, DEPSECVA, and the SECVA with objective oversight and advice regarding the acquisition, management and disposal of VA capital assets.

The OAEM Director is the Senior VA Real Property Officer as well as the Chief Sustainability Officer, which is the senior Department official for the Department's Green Management Program (energy conservation and management, environmental compliance, vehicle fleet management, sustainable building conformance, and related programs). The office oversees capital asset (i.e., buildings and real property leases) activities to ensure effective and prudent portfolio and asset performance management throughout the entire asset life cycle. OAEM develops and disseminates governance policies, processes, and performance measurement systems for the Department's capital asset management programs.

OAEM manages the Department's Strategic Capital Investment Planning (SCIP) process and chairs the SCIP Panel and Board. The Office provides guidance, standards, and technical expertise with respect to individual investments and infrastructure-related programs and initiatives. Additionally, it is responsible for serving as the principal policy office and business advisor regarding capital investment selection and execution, sustainability planning, and real property asset disposal planning. Finally, OAEM is the responsible program office for VA's Enhanced-Use Lease (EUL) program, allowing the Secretary to lease land or buildings to public, private, and/or non-profit partners for up to 75 years to provide housing for homeless Veterans and their families.

Functions and Activities

- Managing the Department's Strategic Capital Investment Planning (SCIP) Process.
- Executing VA's Enhanced-Use Leasing Program to Repurpose Vacant and Underutilized Assets.
- Managing VA's Real Property Performance and Real Property Portfolio.
- Implementing VA's Green Management Program.

Capital Operation and Program Service

Overview

The Capital Operation and Program Service (COPS) provide the day-to-day administrative operations and functions needed to support OAEM. COPS is the central coordinating point for all of OAEM's staff and organizational actions.

Functions and Activities

Provides administrative support to OAEM:

- Correspondence management.
- Space management; .
- Human resource support activities.

- Payroll processing.
- Office supplies inventory maintenance.

Capital Asset Policy, Planning and Strategy Service

Overview

The Capital Asset Policy, Planning and Strategy Service (CAPPS) enables OAEM to serve as the principal policy office and business advisor regarding capital investment selection and execution via the Strategic Capital Investment Planning (SCIP) process. CAPPS coordinates the Department's capital asset policies and investment process. CAPS supports VA's comprehensive planning process for capital programs (major construction, minor construction, NRM, and leases) across the Department and produces a data-driven, merit based strategic plan to support VA's annual capital budget request to OMB and Congress.

Functions and Activities

Manages the Department's SCIP Process:

- SCIP process allows VA to develop an integrated and prioritized list of projects annually.
- Produces the VA Long Range SCIP.
- Prepares VA's annual Capital Program Budget Submission.
- Develops legislative analysis pertaining to capital programs and investments.
- Manages VA/DoD coordination on capital planning issues.

Investment and Enterprise Development Service

Overview

The Investment and Enterprise Development Service (IEDS) is responsible for the management and execution of VA's Enhanced Use Leasing (EUL) program. A EUL is long-term agreement between VA (as lessor) and a non-Federal entity, to use or repurpose underutilized land and/or buildings, to offer an enhanced range of services to Veterans. The current EUL authority is focused on providing supportive housing for Veterans. IEDS conducts the initial due diligence of these real estate deals and negotiates the terms of the EUL with developers ensuring that construction or redevelopment takes place as agreed.

Functions and Activities

Executes the Enhanced Use Lease (EUL) Program

- Addresses issues associated with project planning and development, negotiations, terms, and amendments to a given EUL project.
- Manages the Building Utilization Review and Repurposing initiative designed to help provide housing for homeless and at-risk Veterans and their families.

Capital Asset Management Service

Overview

The Capital Asset Management Service (CAMS) manages VA's portfolio of capital assets, performance monitoring of the portfolio, real property management, disposal and reuse planning, real property data management, and on-going analysis of the portfolio. In support of these responsibilities, CAMS oversees implementation, maintenance and enhancements for information technology systems used to manage VA's real property portfolio through the full asset life cycle, as well as multiple SharePoint sites. The systems managed by CAMS facilitate the management and oversight of underutilized and vacant properties and support the production of multi-year disposal and reuse plans.

Functions and Activities

Provides oversight, management, and analysis of VA's real property portfolio

- Oversees VA's real property disposal process, including planning, reuse, repurpose, and other reporting.
- Maintains responsibility for EUL post transaction oversight.
- Implements Federal Real Property Council (FRPC) reporting requirements and performance tracking associated with VA's real property portfolio.
- Manages the implementation of Office of Management and Budget's (OMB) Real Property Cost Savings and Innovation Plan, including Freeze the Footprint (FTF) by providing guidance, tracking, and reporting on progress.
- Manages the assignment of Accounting Classification Codes for leases and agreements.
- Performs analysis of the Department's portfolio for capital planning purposes, including space analysis and condition analysis, among other factors.
- Represents the Department on various Federal real property groups, such as the Federal Real Property Council and associated working groups, and acts as VA's real property liaison with OMB, General Services Administration (GSA), and Government Accounting Office.
- Manages the GSA delegation process for lease procurements, and lease status tracking at the portfolio level.
- Provides and maintains Department-wide guidance on the Enhanced-Use Lease Program through VA Directive 7415 and VA Handbook 7415.
- Provides and maintains Department wide guidance on post-transaction of Enhanced-Use Lease projects through VA Directive 7454 and VA Handbook 7454.
- Provides systems support for VA's Capital Asset Management System, Capital Asset Inventory System, SCIP Automation Tool, SCIP SharePoint sites, OAEM Records Management tool (Records Center), EUL Information system, and OAEM SharePoint sites.

Generates mandatory reports:

- Produces the OMB-required Real Property Cost Savings and Innovation Plan, including FTF.
- Provides EUL Post-Transaction Compliance monitoring and oversight, including annual EUL Consideration Report.
- Produces required annual reports to GSA (Federal Real Property Profile).

Green Management Program Service

Overview

The Green Management Program Service (GMPS) leads VA's efforts to reduce the agency's environmental footprint, complying with Federal mandates and supporting the Administration's commitment to ensure that the Federal Government led by example. GMPS formulates policy guidance and coordinates enterprise-level operations of VA's energy portfolio.

Functions and Activities

Executes the Department's Green Management Program to include developing policies and monitoring key aspects of VA's sustainability efforts, such as:

- National Environmental Policy Act.
- Energy management.
- Environmental management.
- Vehicle fleet management.
- Sustainable buildings.
- Greenhouse gas emissions management.
- Climate Change Adaptation.
- Environmental Justice.
- Preparing VA's Climate Change Adaptation Planning.
- Compiling and reporting data for OMB's Sustainability/Energy Scorecard.
- Developing VA's Strategic Sustainability Performance Plan and its Environmental Justice Strategy.

Authorities

10 CFR 434
10 CFR 435
10 CFR 436

Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA or Superfund) (42 U.S.C. § 9601 et seq.)
 Clean Air Act of 1970, as amended, (CAA) (42 U.S.C. §7401 et seq.)
 Clean Water Act of 1977 (CWA) (33 U.S.C. § 1251 et seq.)
 Emergency Planning and Community Right-to-Know Act of 1986 (EPCRA) (42 U.S.C. 1011 et seq.)
 Farm Security and Rural Investment act of 2002 (FSRIA), §ion 9002 (7 U.S.C. 8102)
 National Environmental Policy Act (NEPA) (42 U.S.C. 4321 et seq.)
 Food, Conservation and Energy Act of 2008 (FCEA) § 9002 (P.L. 110-246)
 Pollution Prevention Act of 1990 (PPA) (42 U.S.C. §§ 13101-13109)
 Resource Conservation and Recovery Act of 1976 (RCRA) (42 U.S.C. § 321 et seq.)
 Safe Drinking Water Act of 1974 (SDWA) (42 U.S.C. § 300 et seq.)
 Superfund amendments and Reauthorization Act of 1986 (42 U.S.C. 9601 et seq.)
 Toxic Substance Control Act of 1976 (42 U.S.C. § 2601 et seq.)
 P.L. 110-140, 121 Stat. 1492
 P.L. 102-486, 106 Stat. 2776
 P.L. 109-58, 119 Stat. 594
 EP Act Transportation Regulatory Activities
 EO 13327+
 EO 13653
 EO 13690
 EO 13693
 Federal Acquisition Streamlining Act of 1994
 40 CFR Protection of the Environment, §§ 1-1500
 41 CFR Chapter 101, Part 101-18
 48 CFR Federal Acquisition Regulations
 Federal Management Regulation, 102-34
 Federal Management Regulation, 102-5
 GSA's General Reference Guide for Real Property Policy, April 1998,
<http://policyworks.gov/org/main/mp/library/policydocs/refguide.pdf>.
 General Services Administration Regulations (GSAR)
 Government Performance and Results Act of 1993
 P.L. 95-619, 92 Stat. 3206
 42 U.S.C. 8252 et seq.
 Office of Management and Budget Capital Programming Guide
 OMB Circular A-11
 38 U.S.C. § 2405
 38 U.S.C. § 8103
 38 U.S.C. § 8104
 38 U.S.C. §§ 8118, 8122
 38 U.S.C. § 8122
 38 U.S.C. § 8163(c) (4)
 38 U.S.C. § 8122
 38 U.S.C. § 8122(a) (3)
 38 U.S.C. §§ 8161-8169
 40 U.S.C. § 471 et seq.
 42 U.S.C. §§ 4321-4370d
 42 U.S.C. §§ 9601-9675
 VA Directive 0011, 0055, 00560057, 0058, 0059, 0062, 0063, 0064, 0065. 0066. 0067, 0637

VA Handbook 0637

VA EUL Handbook and Directive 7415

Office of Finance

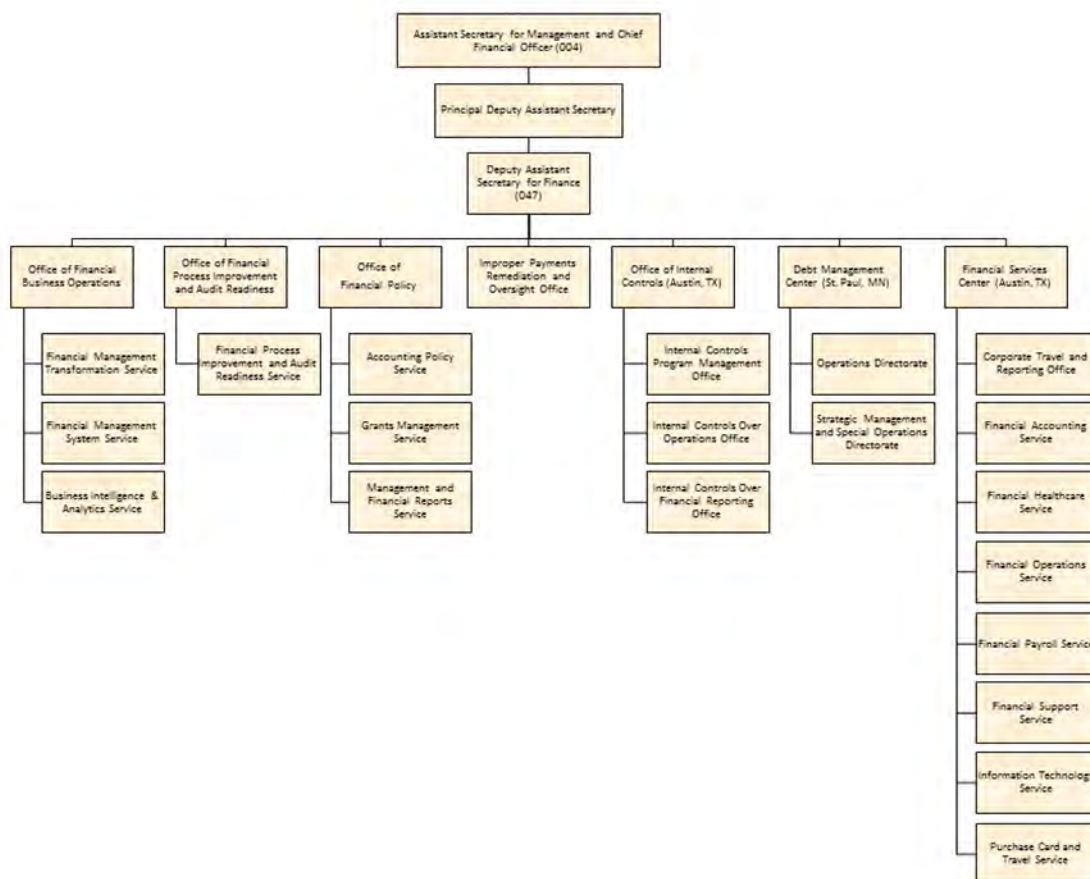


Figure 18 - Office of Finance Organization Chart

[Click here for the alternate representation of the chart](#)

Overview

The Office of Finance (OF) maintains stewardship of Departmental resources; establishes Departmental financial policies, prepares financial reports, and information on VA's appropriations and funds (general, revolving, special, and deposit) for cost and obligation accounting; and, oversees the management of VA's travel and purchase card programs and the performance and effectiveness of trusts established under VA's enhanced-use leasing program. OF continually improves the quality of the Department's financial services, processes payments to vendors, as well as payments to employees for employee travel and relocation, develops and implements long-range financial systems initiatives, and manages and directs VA's financial operations at Central Office and at the Financial Services Center in Austin, TX, and VA's debt management activities at the Debt Management Center in St. Paul, MN. OF also provides Departmental leadership and assistance to VA Administrations and Staff Offices regarding remediation

and reporting of VA improper payments, internal controls, and financial process improvement and audit readiness services, as well as remediation of audit-related material weaknesses and significant deficiencies.

Functions and Activities

- Serves as principal advisor to the VA Chief Financial Officer on all matters related to financial policy, financial reporting, and financial systems.
- Coordinates and compiles data for briefings to OM leadership about OF activities and achievements.
- Directs and oversees new initiatives, objectives, policies, and standards established to improve VA's financial programs, including Department-wide deployment of a new VA Time and Attendance System (VATAS).
- Develops and presents solutions to problems that affect day-to-day program management activities.
- Ensures transformation initiatives are executed and aligned with OM objectives.

Office of Financial Business Operations

Overview

The Office of Financial Business Operations (OFBO) manages VA's financial system modernization effort, a multiyear project to migrate VA from a 30-year old legacy core accounting system to a modern system hosted by a Federal Shared Service Provider (FSSP). In addition, OFBO manages VA's legacy Financial Management System (FMS), the Management Information Exchange (MinX), and the interfaces with other smaller agency financial systems. OFBO ensures these critical systems are maintained with a high degree of integrity and availability, implements any required changes into these legacy systems, and develops long-range financial systems initiatives in partnership with applicable VA Administrations and Staff Offices. Finally, OFBO manages VA's implementation of the Digital Accountability and Transparency Act of 2014 (DATA Act) as well as reporting financial data responsive to the USASpending.gov initiative.

Functions and Activities

- Provides program management for the migration of VA to a FSSP to modernize VA's core accounting system and redesign VA financial business processes.
- Serves as principal advisor to the Deputy Assistant Secretary (DAS) for Finance on all matters related to the legacy core financial systems (FMS and MinX) and the interfaces with other smaller agency financial systems.
- Ensures compliance with the DATA Act, USASpending.gov initiative, and other transparency initiatives, taking the lead to submit data to the Office of Management and Budget (OMB) as required.

Financial Management Transformation Service

Overview

The Financial Management Transformation Service (FMTS) is the program management office responsible for transformation and modernization of VA's financial management environment (systems and business processes). VA's legacy system is 30 years old and there is a clear need for a modern system. Pursuant to OMB Circular M13-08, VA plans to migrate to a Shared Service Provider (SSP) offering a financial systems solution.

Functions and Activities

- Serves as the Program Management Office for Financial Management Business Transformation.
- Coordinates all activities required for the large scale modernization effort.
- Promotes stakeholder involvement throughout the effort in order to ensure modernization activities meet VA's needs.
- Implements best practices and lessons learned for business transformation.

Financial Management System Service

Overview

The Financial Management System Service (FMSS) provides oversight on systems matters relating to accounting, reporting and interfaces that affect FMS and MinX. VA's current financial system framework consists of FMS as the core financial system and a variety of subsidiary and feeder systems which process transactions of various types. MinX is the VA financial report system used to produce financial statements for external reporting. FMSS also plans long-range financial systems modernization initiatives.

Functions and Activities

- Maintains FMS, VA's legacy core accounting system.
- Ensures systems passing financial information to FMS comply with Government-wide accounting principles and standards and with financial systems policy/automated financial data exchange requirements.
- Monitors security related issues (access and maintenance) for both FMS and MinX applications.
- Provides Annual Close support.
- Resolves system issues and implements internal controls in VA accounting systems.
- Plans and manages modernization efforts for VA's financial systems.

Business Intelligence & Analytics Service

Overview

The Business Intelligence & Analytics Service (BI&AS) is VA's lead for complying with the USAspending.gov initiative, the DATA Act, the Federal Innovation and Transformation (FIT) initiative, and the President's Executive Order – *Making Open and Machine Readable the New Default for Government Information*. BI&AS also collects and submits financial data pertaining to OM's Open Data/Data Assets initiative.

Functions and Activities

- Collects and reports VA financial data responsive to the USAspending.gov initiative.
- Collects and submits financial data for OM's Open Data/Data Assets initiative.
- Collects and submits VA financial data for the FIT initiative.
- Collects and reports VA data pertaining to the President's Executive Order, *Making Open and Machine Readable the New Default for Government Information*.
- Reviews the requirements of the DATA Act to determine next steps for collecting data.

Office of Financial Process Improvement and Audit Readiness

Overview

The Office of Financial Process Improvement and Audit Readiness (OFPIAR) provides accountability and sustained focus for remediating financial statement audit findings Department-wide and coordinates business process improvements to improve VA's financial internal controls.

Functions and Activities

- Serves as principal advisor to the DAS for Finance on all matters related to audit readiness.
- Provides oversight, direction, and coordination regarding the annual financial statement audit.
- Reengineers business processes to support the financial system modernization effort.

Financial Process Improvement & Audit Readiness Service

Overview

The Financial Process Improvement and Audit Readiness Service serves as liaison with VA's auditors for the Department's annual financial statement audit. The Service leads the Department and various stakeholders in remediating audit findings, developing processes to enhance business practices, and improving financial internal controls.

Functions and Activities

- Monitors Corrective Action Plans (CAPs) for all identified financial statement audit findings.
- Leads Departmental audit follow up, collecting and submitting documents, artifacts, data extracts and reports requested by the auditors.

- Supports the development and execution of business process improvements across the Department to improve financial internal controls.

Office of Financial Policy

Overview

The Office of Financial Policy (OFP) is responsible for Department-wide financial policy, preparing VA's annual Consolidated Financial Statements, publishing the Agency Financial Report (AFR), and providing guidance to affected offices on grants management issues.

Functions and Activities

- Serves as principal advisor to the DAS for Finance on all matters related to financial policy.
- Creates VA's Consolidated Financial Statements.
- Publishes the AFR.
- Provides oversight, direction, and coordination for VA grants management.

Accounting Policy Service

Overview

The Accounting Policy Service (APS) provides VA-wide financial policy and guidance. Policies include finance and accounting, payroll, travel, financial reporting, cash and debt management, and other Government-wide financial programs and initiatives.

Functions and Activities

- Develops and issues VA financial, payroll, travel, and charge card policies and procedures and ensures their compliance with all financial laws and regulations.
- Responds to financial, payroll, travel, and charge card policy inquiries.
- Reviews and analyzes FMS transactions for US Standard General Ledger, budget object codes (BOCs), and other accounting transactions, including establishing new VA funds.
- Supports changes to cost accounting detail codes including cost centers and BOCs, and answers related cost accounting inquiries.
- Assists in the annual preparation of the Consolidated Financial Statements and other reporting requirements.

Grants Management Service

Overview

The Grants Management Service (GMS) develops grants management policies, and provides guidance on grants management issues to affected offices at all organizational levels within the Department.

Functions and Activities

- Develops and updates grants policy.
- Provides single audit coordination.
- Provides guidance to grant program offices regarding the implementation of new guidance and regulations.
- Develops administrative tools and templates for individual program offices to leverage.
- Responds to *Freedom of Information Act* requests and privacy issues of a financial management nature within VA Central Office (VACO).

Management and Financial Reports Service

Overview

The Management and Financial Reports Service (MFRS) prepare VA's financial statements and related financial information in accordance with the laws and regulations of the United States Government, principally the Chief Financial Officers Act (CFO Act) of 1990 and the Government Management Reform Act (GMRA) of 1994. The principal financial statements are prepared to report the financial position and results of operations of VA pursuant to the requirements of 31 U.S.C. 3515 (b).

Functions and Activities

- Prepares financial statements, footnotes, and supplementary financial information for VA's AFR.
- Assists in the coordination of the financial statements audit, preparing the bulk of auditor requested schedules and responses to auditor points/questions and reconciliations.
- Manages and prepares deliverables to assist with the implementation of CAPs related to key financial statement audit findings.
- Reports VA-wide financial information monthly to Treasury and OMB for Government-wide consolidation.
- Assists in financial policy development and review.

Improper Payments Remediation and Oversight Office

Overview

The Improper Payments Remediation and Oversight (IPRO) Office is responsible for overseeing the Department's compliance with the Improper Payments Elimination and Recovery Act (IPERA) and its amendments. IPRO is charged with improving leadership, oversight, and guidance for the Department on improper payment estimation and reporting as well as strategically evaluating current Governance processes and procedures to identify opportunities for improvements.

Functions and Activities

- Serves as principal advisor to the DAS for Finance on all matters related to VA improper payments.

- Provides guidance and support to VA Administrations and VACO Staff Offices regarding remediation, effective measurement, and reporting of improper payments.
- Provides milestone target dates annually for IPERA program.
- Issues and updates IPERA policy and guidance.
- Reviews and provides recommendations on completed pre-risk assessments and risk assessments.
- Provides oversight and support to ensure root causes are accurately identified in the development and implementation of effective CAPs to drive remediation of improper payments.
- Coordinates all data collection and reporting requirements in compliance with OMB timelines for reporting on IPERA activity.
- Prepares and reports IPERA Program activities annually in the AFR.
- Manages coordination of the annual OIG audit of IPERA compliance.
- Reports quarterly on the High-Dollar Overpayments that occurred in programs susceptible to significant improper payments to the OIG and to the Council of Inspectors General on Integrity and Efficiency, and to make this report available to the public.

Office of Internal Controls

Overview

The Office of Internal Controls (OIC) is the Department's internal controls organization and is located in Austin, Texas. OIC consists of a Director's office and 3 offices – Internal Controls Program Management Office, Internal Controls over Operations Office, and Internal Controls over Financial Reporting Office.

Functions and Activities

- Serves as principal advisor to the DAS for Finance on all matters related to internal controls.
- Provides oversight, direction, and coordination for the overall internal controls operation.

Internal Controls Program Management Office

Overview

The Internal Controls Program Management Office is responsible for coordinating VA's internal control program, culminating in the Secretary's annual Statement of Assurance published in the AFR.

Functions and Activities

- Coordinates internal controls assessment activities across VA, including preparing the Secretary's annual Statement of Assurance.

- Sets and communicates guidance regarding internal controls and all Federal Manager's Financial Integrity Act of 1982 (FMFIA) related assessment activities across VA including developing tools and templates to support VA's internal controls program.
- Provides training on internal controls, policy requirements, and use of tools and templates.

Internal Controls over Operations Office

Overview

The Internal Controls over Operations Office develops and implements a program to assess and improve internal controls over operations across VA through testing operational controls and conducting reviews of emerging issues.

Functions and Activities

- Coordinates VA-wide operational risk assessment to evaluate risk of VA assessable units and prioritize evaluation and validation activities.
- Identifies requirements for assessable units to implement in order to evaluate internal controls over operations.
- Supports assessable units on their operational assessments – providing guidance, training, tools & templates – as well as monitoring/oversight to ensure that the assessments are performed.
- Performs validation testing of operational internal controls.
- Performs reviews of emerging issues.

Internal Controls over Financial Reporting Office

Overview

The Internal Controls over Financial Reporting Office reviews internal controls over financial reporting.

Functions and Activities

- Performs assessments of VA's internal controls over financial reporting.
- Tests VA's internal controls over financial reporting.
- Assists with the remediation of deficiencies found in the assessment and testing of VA's internal controls over financial reporting.

Debt Management Center

Overview

The DMC operates as an Enterprise Center within the VA Franchise Fund and provides debt collection and financial services on a fee-for-service basis to VA Program Offices, NCA, VBA and VHA.

Functions and Activities

- Serves as principal advisor to the DAS for Finance on all matters related to debt collection operations for its customers.
- Provides oversight, direction, and coordination for the overall debt collection operation.

Operations Directorate**Overview**

The Operations Directorate is responsible for responding to Veterans' written and telephone inquiries, processing refunds, and employee development and supervision.

Functions and Activities

- Manages all daily debt and financial functions and processes.
- Monitors 192 toll-free Veteran facing telephone lines.
- Provides statistics, trends and estimates for workload analysis and business decisions.

Strategic Management and Special Operations Directorate**Overview**

The Strategic Management and Special Operations Directorate provide administrative support for the DMC and the daily operation of the DMC's mail processing and workload related to education benefits and congressional inquiries.

Functions and Activities

- Reviews, monitors and recommends changes to financial policy as it relates to debt collection activities.
- Manages the daily distribution of mail and check processing.
- Provides human resources liaison services required to support daily operations.
- Provides procurement services in terms of contract support and filling the operating needs of the DMC.
- Creates, monitors and implements DMC's operating budget and the related business plan.
- Coordinates all facility issues such as maintenance, utilities and renovations.
- Manages, trains, and supervises DMC's collections staff.

Financial Services Center

Overview

The FSC operates as an Enterprise Center of the VA Franchise Fund and provides an array of financial management and professional and administrative services on a fee-for-service basis to VA and other Governmental agencies.

Functions and Activities

- Serves as a principal advisor to the DAS for Finance, and is accountable to the Franchise Fund Board of Directors, on all matters related to the operation of the FSC.
- Manages FSC's Executive Steering Committee and Business Process Review meetings.
- Provides oversight for all FSC service lines and FSC's Equal Employment Opportunity program.
- Coordinates hiring actions and other human resource efforts.
- Disseminates communications throughout FSC.
- Provides procurement support.
- Performs internal business office functions.
- Facilitates employee training and development.
- Provides project management support.
- Executes financial management related disaster recovery activities.
- Represents the FSC on SSP related working groups.
- Serves on the E-Gov Travel Service 2 (ETS2) Executive Steering Committee.

Corporate Travel and Reporting Office

Overview

The Corporate Travel and Reporting Office (CTRO) oversee VA's conference policies and mandatory reporting. CTRO is also responsible for certain VA travel-related activities, including serving as the VACO Federal Agency Travel Administrator (FATA), managing VA's official passport activities, and processing VA travel policy exception requests.

Functions and Activities

- Provides policy, oversight and review of VA's conference activities.
- Develops and delivers congressionally mandated quarterly reports per title 38 U.S.C §517; develops and delivers annual reports as prescribed by OMB Memorandum M-12-12 and P.L. 113-46.

- Monitors VA conference policies and procedures (VA Financial Policy Volume 14 Chapter 10) and ensures compliance with current laws and regulations.
- Develops and manages the Conference Oversight and Reporting Knowledgebase (CORK) Web-based application.
- Assists VACO's 5,500 Washington, DC-based travelers with using E-Gov Travel Service 2 (ETS2), Concur Government Edition.
- Processes requests for waivers and authorized exceptions to travel policy.
- Processes official VA passport and visa requests for international travelers.
- Serves as the sole custodian of all Diplomatic and Official passports issued to VA employees.

Financial Accounting Service

Overview

The Financial Accounting Service (FAS) is responsible for financial reports and accounting, nationwide accounting services and common administrative fiscal services for 12 stations. One of the primary functions of FAS is to ensure accounting transactions are properly recorded, reconciled, and reported to Treasury and OMB. FAS staff also provide Intragovernmental Payment and Collection System, Intragovernmental Reconciliation, Treasury Reconciliation, Agent Cashier Accountability, Financial Systems Oversight, and FMS annual close services to VA.

Functions and Activities

- Prepares and reconciles financial reports.
- Provides VA nationwide, station and intragovernmental accounting services.
- Coordinates VA implementation of Treasury modernization initiatives and provides Treasury reconciliation services.
- Performs financial systems oversight and serves as a liaison between VA field activities and IT staff operating FMS and other financial systems.
- Maintains VA's Intragovernmental Payment and Collection System and agreement repository.
- Processes collections and prepares income statements for all Enterprise Centers.
- Processes FMS service requests.
- Provides Agent Cashier accountability.
- Performs functional FMS Annual Close coordination.
- Provides financial policy support including reviewing all new FMS general ledger accounts and standard transactions.

- Offers financial system and accounting training.

Financial Healthcare Service

Overview

The Financial Healthcare Service (FHS) is responsible for the payment of medical claims for its VA and other government agency (OGA) customers. FHS provides a wide range of services associated with the payment of medical claims starting with receipt and intake of the claim, Electronic Data Interchange or optical character recognition (OCR) conversion of paper claims, the calculation of a reimbursement amount on the claim using a commercial off-the-shelf claims adjudication engine, and the payment and generation of an explanation of benefits to the provider. In addition, a web based medical care authorization portal is available along with a portal accessible by the medical providers to check their claim status.

Functions and Activities

- Supports claim processing for the Department of Homeland Security (DHS) Immigration and Customs Enforcement Health Service Corps (IHSC) and the Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) .
- Processes contract dialysis claims for VHA.
- Processes Care in the Community and Choice medical claims via the Fee Basis Claims System (FBCS) for VHA.
- Partners on a major pilot project with the VHA Non-VA Purchased Care Office to develop a comprehensive claims processing system designed to be the future-state system for Purchased Care.
- Provides Enrollment and Eligibility, Referral Authorization, and Hospital Notification services to VHA to assist in the processing of non-VA medical claims.
- Processes medical claims and payments to families stationed at Camp Lejeune, North Carolina from Jan 1957 to December 1987.

Financial Operations Service

Overview

The Financial Operations Service (FOS) is responsible for a full range of financial operations, including electronic vendor payment services, customer relationship management, vendor file maintenance, and payment resolution services. FOS's electronic invoicing service, in partnership with commercial partners, incorporates innovative technology to eliminate paper invoices, reduce manual processing, improve quality, and reduce operating costs. FOS' state of the art workflow system includes capabilities such as automated business rules, 3-way matching, approval interfaces, automatic payment transaction creation, service oriented architecture, and automated correspondence.

Functions and Activities

- Provides commercial vendor payment services.

- Performs vendor file maintenance services.
- Performs customer relationship management services.

Financial Payroll Service

Overview

The Financial Payroll Service (FPS) provides a “one stop” resource for VA payroll offices to resolve all payroll related issues. FPS Field Support staff provide local payroll support to more than 15,000 employees across the country including VACO, NCA, OIT and selected VBA stations. Additionally, FPS provides payroll training and assistance to VHA payroll offices. FPS Payroll Support Operations staff provide Tier 1 customer service support, procedural guidance for settlement actions and regulatory changes, and payroll retirements. FPS Operations staff conduct the deployment and sustainment of stations transitioning to the new VATAS. These services include customer service support and requirements development for system updates. FPS Payroll/HR Systems Service staff provide management for the VA’s payroll and related systems to ensure accurate pay for VA’s diverse Title 5, Title 38, and hybrid employees.

Functions and Activities

- Provides local payroll customer service.
- Provides nationwide payroll support and system services.
- Provides VATAS operational and deployment services.

Financial Support Service

Overview

The Financial Support Service (FSS) provides an effective and supportive risk-based internal control program for FSC operations, conducts quality control reviews of FSC payment operations, plans and conducts auditing activities to identify, prevent, or recover VA improper payments, and provides grants auditing support services to VA entities. FSS also provides data analysis support to other FSC and VA entities to help identify key operational problem areas, improvement opportunities, and to respond to internal and external inquiries.

Functions and Activities

- Coordinates VA and FSC performance measurement and monitoring.
- Provides audit recovery services.
- Performs internal audit and oversight.
- Provides grant auditing services.
- Provides data analytics services.

Information Technology Service

Overview

The Information Technology Service (ITS) is comprised of Office of Information and Technology employees and information & technology (IT) contractors. These critical resources support all aspects of the software development lifecycle as well as manage and maintain FSC's IT infrastructure. ITS assures FSC's local area network, desktops, mobile devices and data repositories are secure and meet all VA and Federal information security requirements.

Functions and Activities

- Performs development/maintenance of in-house applications.
- Assesses FSC enterprise and system architecture.
- Performs capacity planning.
- Performs IT-related continuity of operations and disaster recovery functions.
- Performs database, server and desktop administration.
- Provides IT customer service help desk support.
- Provides Electronic Commerce and Electronic Data Interchange consulting, processing, and data analytics services.

Purchase Card and Travel Service

Overview

The Purchase Card and Travel Service (PCTS) provide centralized oversight and administration of the Travel, Lockbox and Purchase Card Programs to ensure compliance with various Public Laws, Federal Regulations, and Agency policies.

Functions and Activities

- Serves as the US Bank liaison to manage VA Purchase, Travel, Fleet, FEE, and Prime Vendor accounts.
- Performs charge card administration in US Bank Access On-Line for Purchase, Fleet, and Travel cards.
- Performs charge card management services which include responding to Fleet, Prime Vendor, Travel, and Purchase Card inquiries and audit requests.
- Performs Lockbox duties to include processing debit vouchers, deposit tickets, rejected checks, rejected credit cards, and processing exceptions to medical co-payments, on behalf of the Veteran.
- Provides travel and relocation assistance for employees who have Temporary Duty Travel (TDY) and Permanent Change of Station (PCS) requirements.

- Oversees and performs reviews on travel obligations and disbursements in various financial management systems.
- Provides program management for the E-Gov Travel Service 2 (ETS2) and the PCS Travel Portal financial systems for new enhancements, regulatory updates, and system issues.
- Manages TDY, PCS, and Charge Card program training.

Authorities

Government Management Reform Act of 1994

P.L. 103-356

Military Quality of Life and Veterans Affairs Appropriations Act, 2006

P.L. 109-114

OMB Memorandum 11-35, dated September 21, 2011

OMB Memorandum 12-12, dated May 11, 2012

P.L. 112-154, § 707

VA Chief of Staff Memorandum dated September 26, 2012

OMB Circular A-123

P.L. 97-255

P.L. 109-282

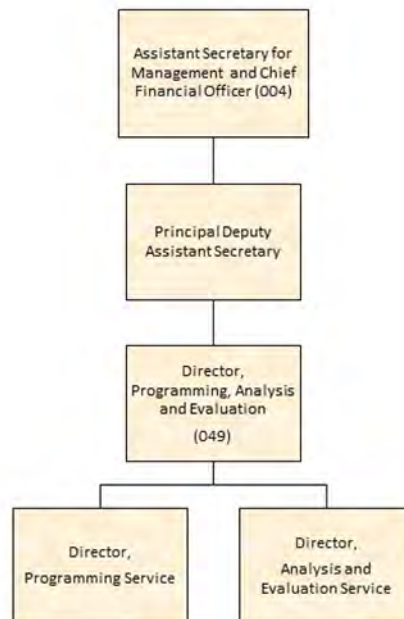


Figure 19 - Office of Management Office of Programming, Analysis and Evaluation

[Click here for the alternate representation of the chart](#)

Office of Programming, Analysis and Evaluation

Overview

The Office of Programming, Analysis and Evaluation's (PAE) mission is to improve service to our Veterans by enabling the VA to make evidence-based resource and program decisions and promote Programming excellence. PAE is VA's independent, analytical voice for supporting improved cost estimation, alignment of resources, and decision-making to achieve the Department's strategic goals and objectives. PAE leads key components within the Department's Managing for Results (MFR) process for connecting the forecasting of Veterans' needs (requirements) to strategy and resource planning (budget), in order to optimize our services to Veterans.

Functions and Activities

- PAE's Programming Service leads the Department's transition to a true requirements-driven, multi-year resource allocation process.
- PAE's Analysis and Evaluation Service is the independent assessment organization that provides VA leadership with objective analysis to inform strategic decision-making.

Programming Service

Overview

The Department's Programming process is the forcing function that provides the disciplined framework to develop, assess, and prioritize multi-year resource requirements from the Veteran's perspective in order to effectively achieve VA's mission.

Functions and Activities

- Serves as the integrator between the Department's Mission Requirements Planning and Budget phases within the MFR process.
- Leads the Department's multi-year Programming process, providing the enterprise-view necessary for VA leadership to make well informed, long term resource allocation decisions.
- Develops forward-looking and integrated Programming capabilities VA-wide.
- Supports integration, validation, and prioritization of multi-year resource requirements at the enterprise level and leads analyses and reviews of VA programs.
- Manages VA's Programming data and associated programmatic alignment with other MFR phases.

Analysis and Evaluation Service

Overview

The Analysis and Evaluation Service applies advanced analytical and program evaluation techniques to improve strategic planning, program integration, and resource decision-making across the Department as directed by VA leadership.

Functions and Activities

- Supports the MFR process and develops analytic capabilities to enhance strategic decision-making at VA.
- Serves as the Departmental expert on cost analysis and cost estimating through the development of cost policies and procedures, gathering best practices, and providing analytical guidance.
- Develops and promotes a centralized repository of approved analytical tools, techniques, and methods to shape program planning and resource requirements.
- As directed, conducts independent program evaluations to assess the design, implementation, improvement, and/or outcomes in order to demonstrate program effectiveness and value to stakeholders.
- Performs independent, objective analysis of and provides assistance with studies, models, reports, and any other items deemed important by the Department.
- Manages the Analysis Resource Center, and advisory group and repository dedicated to furthering and improving analysis across the Department.

Authorities

Title 38 U.S.C. § 308(b) (3) (March 31, 2011) - (b)

Title 38 U.S.C. § 527 (March 31, 2011) - Evaluation and data collection

Title 48, Chapter 1 of the United States Code of Federal Regulations, Federal Acquisition Regulation (FAR), September 19, 1983

The Federal Acquisition Streamlining Act of 1994

Clinger-Cohen Act of 1996

OMB Circular A-109, Major System Acquisitions (April 5, 1976)

OMB Circular A-94, Guideline and Discount Rates for Benefit-Cost Analysis of Federal Programs (October 29, 1992)

Government Performance Results Act of 1993 (P.L. 103-62) Sec. 1116 (d) (5)

GPRA Modernization Act of 2010 - §2. Strategic planning amendments. § 306

OMB Memo Increased Emphasis on Program Evaluations M-10-01 (October 7, 2009)

OMB Memo Evaluating Programs for Efficacy and Cost Efficiency M-10-32 (July 29, 2010)

OMB Memo Use of Evidence and Evaluation in the 2014 Budget M-12-14 (May 18, 2012)

Office of Management and Budget (OMB) Memorandum M-13-17 (July 26, 2013) – Next Steps in the Evidence and Innovation Agenda

OMB Memo Fiscal Year 2016 Budget Guidance (M-14-07) (May 5, 2014)

GAO-09-3SP, Cost Estimating and Assessment Guide (March 2009)

GAO-12-629, Information Technology Cost Estimation (July 2012)

Office of Information and Technology

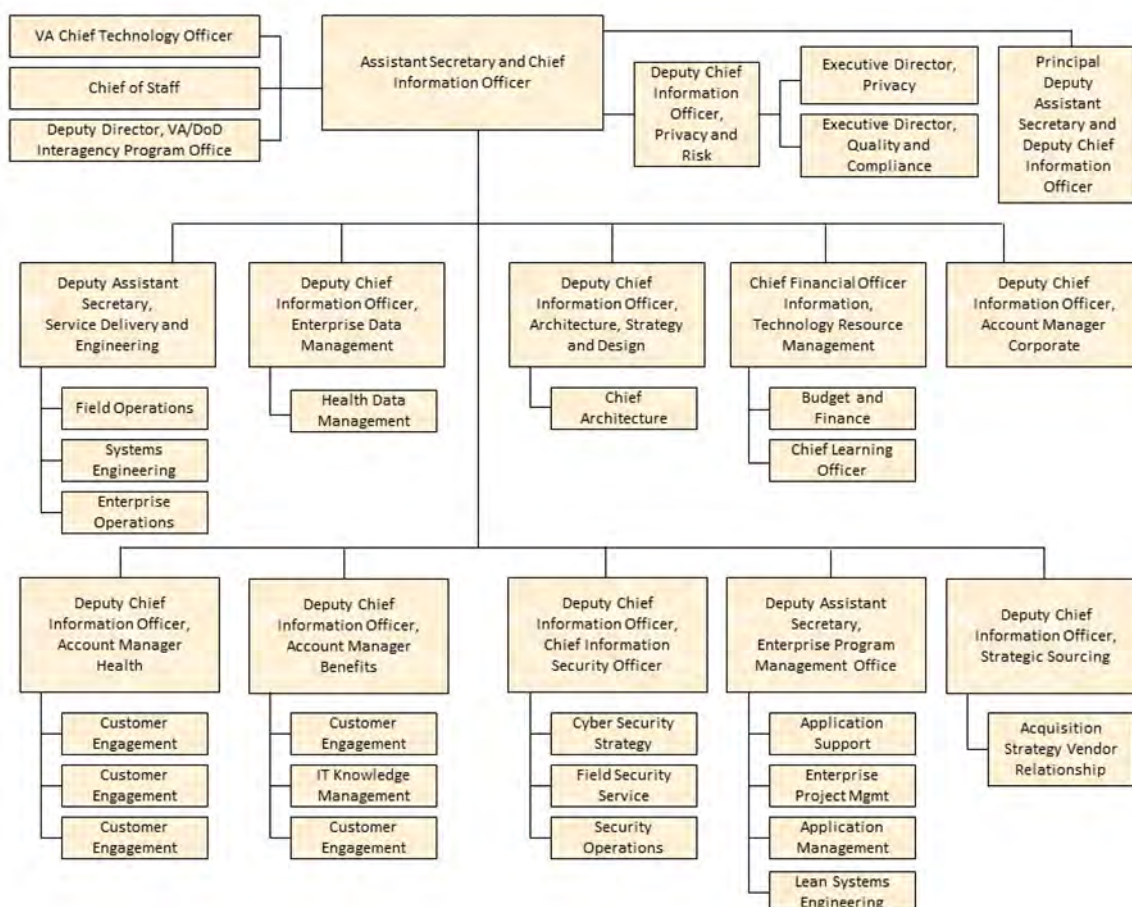


Figure 20 - Office of Information and Technology Organization Chart

[Click here for the alternate representation of the chart](#)

Mission

Become a world-class organization that provides a seamless, unified Veteran experience through the delivery of state-of-the-art technology. Collaborate with our business partners to create the best experience for all Veterans.

Assistant Secretary for Information and Technology and Chief Information Officer

Overview

The Assistant Secretary for Information and Technology and Chief Information Officer (AS/CIO) leads the Office of Information and Technology (OI&T). OI&T delivers available, adaptable, secure, and cost-effective technology services to VA—transforming the Department into an innovative, 21st century organization—and acts as a steward for all VA's IT assets and resources. OI&T delivers the necessary technology and expertise that supports Veterans and their families through effective communication and management of people, technology, business requirements, and financial processes.

Functions and Activities

- Oversees information protection policies, planning, and activities in order to improve how VA and its partners safeguard sensitive data.
- Approves the Enterprise Architecture and IT Strategic Plan objectives and performance measures necessary to support VA business lines.
- Sets the precedence for customer service excellence through customized IT services that will identify and define innovative solutions that meet OI&T business partner's needs while building trusted relationships with stakeholders.
- Oversees the direction of financial management, human capital management, IT asset management and procurement activities for OI&T.
- Provides the necessary guidance for IT support of all operational and maintenance activities throughout the VA.
- Presents a single vision for all enterprise application development activities pertaining to planning, developing(or acquiring), and testing applications .

Principal Deputy Assistant Secretary

Overview

The Principal Deputy Assistant Secretary for OI&T (PDAS) serves as the Deputy Chief Information Officer (DCIO) for OI&T with the responsibility to oversee and facilitate all IT activities of the Department. The PDAS is responsible for all information technology programs with the Department of Veterans Affairs (VA) and is tasked with improving the effectiveness of program operations and assisting line and staff organization in the performance of their missions.

Functions and Activities

- Carries out strategic planning.
- Ensures quality improvement throughout OI&T.
- Responsible for the executive leadership over the Deputy Assistant Secretaries (DAS) and/or Deputy Chief Information Officers (DCIO) assigned to OI&T as well as the day to day management of the administrative staff assigned to the OI&T.
- Makes recommendations to ensure maximum effectiveness and efficiency in the use of all resources.
- Oversees all Human Capital Management support for OI&T employees.

Human Capital Management

Overview

The Office of Human Capital Management (HCM) provides OI&T a myriad of human capital functions to ensure OI&T develops, deploys, and continuously improves upon the effective management of OI&T human capital.

Functions and Activities

- Directs HCM activities through the functions of HCM Operations, Relationship Management, HR Servicing Transformation, Transformation & Planning, and the organizational business office
- Represents OI&T on all department and external to department HCM related matters
- Develops and directs the HCM strategic goals to support the mission of OI&T
- Provides direct oversight to the OI&T SES management program including classification, performance plans, and awards
- HCM Operations

Overview

The Office of HCM Operations provides data reporting, processing and records (PAR) processing, programs & policy, and recruitment.

Functions and Activities

- Perform data reporting related to HCM performance management indicators
- Manage career promotions, reassignments, details, awards & performance appraisals, realignments, and time and leave program
- Develop position descriptions, maintain OI&T position descriptions, and liaison with HR Classification
- Perform position management and develop OI&T staffing model
- Manage HCM programs including telework, EAP, OWCP, reasonable accommodation, awards & performance guidance, SLRP, tuition reimbursement
- Manage all recruitment including recruitment requests, screening & interview, and final offers

HR Servicing Transformation

Overview

The Office of HR Servicing Transformation develops the strategy and plans to consolidate and transition all HR liaison activities to the office of HCM.

Functions and Activities

- Construct and analyze the current OI&T HR liaison functions
- Develop strategy and plan to consolidate all remaining HR liaison functions throughout OI&T
- Develop transition plan to transfer employees and work assignments for all employees performing HR functions to the office of HCM

Relationship Management

Overview

The Office of Relationship Management provides human capital account management representation to all OI&T functional organizations.

Functions and Activities

- Provide direct customer service to senior leaders, supervisors and employees on HCM related matters
- Receive all HCM work requests and assign to appropriate HCM Team
- Provide interface between customers and HCM to ensure appropriate prioritization of work
- Track and analyze all HCM actions and provide performance metrics to customers
- Develop methods to improve HCM customer experience

Transformation and Planning

Overview

The Office of Transformation and Planning provides OI&T with strategic organization design and solutions to continuously evolve by incorporating emerging requirements within the organizational structure.

Functions and Activities

- Develop architecturally sound organization structures
- Assist in the development of complex supervisory and technical positions
- Provide oversight for large scale (involving two or more functional organizations) realignments, reorganizations, or transformation efforts.
- Develop HCM strategic plan, succession planning, and workforce planning
- Provide contractual oversight for the development of the HCM strategic plan and OI&T staffing model

Business Office

Overview

The Business Office provides various life support functions to all front office organizations in order to sustain continuous business operations.

Functions and Activities

- Perform all budget related activities
- Provide conference and travel administration and oversight

- Perform training oversight
- Perform equipment, space management, and logistics oversight

Chief of Staff

Overview

The Chief of Staff (COS) is a member of the OI&T management team, providing direct advice and high-level technical support to the Assistance Secretary and the Principal Deputy Assistance Secretary for OI&T, as well as Senior Executive Schedule (SES) leadership Teams.

Functions and Activities

- Provides leadership and advisory services that are critical to achieving optimal overall program balance in relation to VA's mission.
- Promotes and maintains successful and productive interactions with a wide variety of entities.
- Makes recommendations to ensure maximum effectiveness and efficiency in the use of all resources.
- Manages OI&T's delegations of signature authorities for statutory and regulatory actions that OI&T staff is authorized to make.
- Directs and oversees OI&T Strategic Communications.

Interagency Program Office

Overview

The Department of Defense/Veterans Affairs Interagency Program Office (DoD/VA IPO) was established by the National Defense Authorization Act in FY 2008 (NDAA FY08) and re-chartered with the NDAA FY2014, creating a new charter signed in Dec 2013. The DoD/VA IPO acts as the single point of accountability in the development and implementation of electronic health records (EHR) systems or capabilities that allow for full interoperability of health care information between the Departments. To further this purpose, the DoD/VA IPO leads the Departments' efforts to implement national health data standards for interoperability and is responsible for establishing, monitoring, and approving the clinical and technical standards profile and processes to ensure seamless integration of health data among the two Departments and private health care providers.

Functions and Activities

- DoD/VA IPO leads a combined VA and DoD effort to identify, adopt, and where necessary assist in the development of national and international health data standards that allow for full information interoperability between the Departments. Specific tasks described in the charter include:
- Actively engage with national and international health standards setting organizations, to ensure their resulting standards (e.g., data formats, messaging, exchange protocols, meaningful use, usability, privacy, security and safety) meet the needs of VA and DoD.

- Oversee and approve VA and DoD adoption of and mapping to national and international health standards, an essential step toward interoperability, that: (a) requires the Departments to express the content and format of health data using a common language to improve the exchange of data with each other and the private sector and that: (b) ensures Department clinicians have an integrated, computable view of a patient's comprehensive health record which can be trended to show health care information about a patient over time and provide expedient, improved health care treatment.
- Identify data domain and messaging standards for department information technology (IT) solutions necessary to create a seamless integration of VA and DoD health care record data based on functional use cases.
- Monitor and report on: (a) the Departments' use of IPO approved national and international health standards and, (b) the Departments' compliance with the IPO's identification of data domain and messaging standards for department IT solutions necessary to create a seamless integration of VA and DoD health care record data.
- Continuously identify methods and opportunities to leverage DoD and VA health IT solutions such as health information technology (HIT) portfolio reviews that interface with each Department's modernized system to verify clinical and technical data interoperability.

Office of Privacy and Risk

Overview

The Office of Privacy and Risk advises the AS/CIO on several complex and sensitive Privacy and Risk issues that cross organizational boundaries within the Department. In addition to interfacing with external agencies, such as OMB, GAO, OIG, and Congress, the Office of Privacy and Risk works to assure department-wide compliance with all applicable laws, policies and standards.

Functions and Activities

- Leads a comprehensive Quality and Compliance effort across the spectrum of OI&T functions and services.
- Oversees the Risk Management effort to address all enterprise IT risks .
- Directs the department's Privacy Program quality compliance.

Office of Quality and Compliance

Overview

The OI&T Office of Quality and Compliance (Q&C) instills and promotes a culture of quality across OI&T in order to optimize the collaborative efforts of OI&T and its business partners to create the best possible experience for all Veterans by improving and maintaining the quality of OI&T processes, products, and services, while assuring compliance to appropriate laws, policies, and standards.

Functions and Activities

- Provides centralized OI&T quality and compliance direction and oversight.

- Directs quality and compliance assurance efforts across OI&T .
- Directs quality and compliance assessment efforts across OI&T .
- Directs and manages quality and compliance reporting associated with OI&T performance management and compliance with oversight commitments.
- Provides quality management, risk management, and audit readiness management oversight across OI&T.
- Provides Independent Verification and Validation (IV&V) consisting of Systems Integration Testing and a full range of Quality Assurance services.

Quality and Compliance Assurance

Overview

The Office of Quality and Compliance Assurance directs quality and compliance assurance efforts, including issue identification and resolution through strategy & governance, audit readiness, and risk management.

Functions and Activities

- Enforces OI&T Quality and Compliance policy, strategy and framework.
- Integrate and de-conflict policy and stands requirements.
- Identify and track areas subject to oversight and audit.
- Lead Risk Management efforts within OI&T.

Special Projects

Overview

The Special Projects Office is responsible for identifying and prioritizing specific areas where change (e.g. process, technology, organization) has the potential for delivering tangible improvement to OI&T operations.

Functions and Activities

- Perform change impact analysis .
- Leads special projects assigned by the Chief Information Officer .

Quality and Compliance Assessment

Overview

The Office of Assessment leads Q&C efforts including various issue identification and resolution development. Q&C assesses programs and projects (e.g. products, applications and solutions) for effective and efficient planning and execution.

Functions and Activities

- Assess intake requirements .
- Evaluate applications and solutions for quality, compliance and effectiveness .
- Monitor pre-production testing and evaluation activities .

Quality and Compliance Reporting

Overview

The Office of Quality and Compliance Reporting directs Q&C reporting efforts for a myriad of missions and tasks across the Office of Privacy and Risk, including issue identification and resolution recommendations. Additionally, the office works to resolve performance issues in collaboration with leadership and process/metric owners.

Functions and Activities

- Interact with oversight activities across Q&C to understand the organizational intent in order to provide proper reporting
- Provide guidance to ensure implanting activities understand compliance requirements.
- Generates a myriad of quality and compliance status reports.
- Coordinate and report oversight compliance status to various levels of OI&T leadership

Office of Privacy

Overview

The Office of Privacy works across OI&T (and VA) to integrate via policy and oversight privacy considerations, requests for information, manage official records, and ensure that the confidentiality and availability of VA sensitive information and information systems are protected. The Office of Privacy is made up of five services: the Privacy Service, Enterprise Records Service, Identity Safety Service, Data Breach Response Service Incident Resolution Service and the FOIA Service. Individual administrations and staff offices have “operational authority” for transactional privacy, records, and FOIA activities. Outside of OI&T, the Office of Privacy serves in an oversight, compliance, and consultant role. In the event of a data breach/loss, the Data Breach Response Services assumes operational control of VA’s response and statutory requirements.

Functions and Activities

- Directs VA's privacy program including conformance with the Health Insurance Portability and Accountability Act (HIPAA) and the Electronic Communications Privacy Act, COMSEC regulations, nondisclosure statutes, OMB guidance on computer cookies, OMB Circular A-130, Government Paperwork Elimination Act, user authentication, insider threat and identity theft.
- The Office of Privacy ensures VA policies are in compliance with regulatory requirements and legislated mandates governing those programs; promulgates Department-level privacy policy, procedures, and guidelines that implement Federal laws and regulations, and provides guidance on policy implementation; and reviews proposed privacy policies in its areas of responsibility to ensure issues are adequately addressed.
- Ensures that Privacy Impact Assessments or appropriate validations are completed for all IT systems.
- Manages the Department's computer matching program and systems of records programs required under the Privacy Act.
- Works cooperatively across VA and each of the Administrations and staff offices in overseeing Veteran rights to inspect, amend, and restrict access to privacy-protected PII.
- Works with all Administrations and Staff Offices to determine appropriate measures to effectively reduce the use of Social Security numbers as mandated by OMB.
- Directs the VA's information access program under the Freedom of Information Act (FOIA) and the OPEN Government Act to release information on VA programs, policies, and items of interest to the Veteran community.
- Responds to requests for information from the public under the FOIA and requests under the Privacy Act for information about individuals that is being kept by Federal agencies. Determines whether the information can be released in whole or in part according based on the provisions of the FOIA.
- Identifies and publishes information concerning the operations and program within VA determined to be of interest to the Veteran community and to the public.
- Directs VA's Enterprise Records program to provide support to the various components within VA on preparing and publishing directives, handbooks and other guidance documents and oversight for compliance with the Federal Records Act (44 U.S.C. §3101).
- Provides oversight on the VA Release of Names and Addresses (RONA) program.
- Directs the Incident Resolution Service to identify, communicate, and mitigate information security and privacy incidents across the Department. The Office conducts data breach analysis to discover appropriate corrective action that must be taken to safeguard protected information. Establishes and maintains a formal incident response capability and provides pertinent information on incidents to the appropriate organizations.

- Facilitates the national Data Breach Core Team to review, discuss, and provide resolution for nationwide VA incidents.
- Prepares data breach reports provided to Congress by the SECVA.
- Coordinates communications and alerts about critical emergency incidents.
- Directs the Identity Safety Service to provide Identity Fraud Analysis and Notification reviews based on data maintained in VA Systems.
- Directs VA's identity safety program including the Identity Fraud Monitoring, Verification and Mitigation (IFMVM) program, which provides pro-active identity theft monitoring for all Veteran identity data housed in the BIRLS database, as well as creating an Identity Theft Communication Plan and identity theft policy for the VA enterprise. The VA Identity Safety Service also provides a toll-free Identity Theft Help Line (1-855-578-5492) for Veterans who feel they may have been victimized by identity theft as well as the "More Than a Number" website (<http://www.va.gov/identitytheft/>), which provides identity theft resources and contacts. Other activities include strategic partnerships with outside organizations to prevent identity theft, such as the University of Texas Center for Identity and the Medical Identity Fraud Alliance.

Office of Enterprise Data Management

Overview

The Office of Enterprise Data Management (EDM) develops the strategy, guidance and implementation and governance for VA's "to be" technology environment. To support VA's overall mission and strategy to meet emerging business needs to better serve Veterans, the EDM creates and implements a more effective and efficient enterprise IT environment to meet business needs while maintaining a consistent approach the System and Software Development Lifecycles (SDLC).

Functions and Activities

- Provides tactical and strategic direction in the areas of information management.
- Provides business intelligence analytics and analytic technologies .
- Provides data management, mining, and warehousing .
- Assesses data quality and consistency across platforms, products and geographical areas.

Architecture, Strategy, and Design

Overview

Architecture, Strategy, and Design (ASD) provides a framework of strategies, architecture, policies, procedures, guidance, processes, and governance to ensure IT programs and projects are designed and executed to satisfy current and future business needs of VA, while exercising proper stewardship of resources and maintaining transparent operations.

Functions and Activities

- Performs strategic planning functions for OI&T to facilitate its ability to meet mission requirements and customer demand.
- Develops and maintains the VA's Enterprise Architecture (VA EA)--an integrated technical, business, systems, and data architecture, used to facilitate Agency transformation and enforce standards.
- Provides systems design, engineering, and integration standards.
- Leads OI&T continuous process improvement efforts.
- Standardizes processes and operates and maintains the OI&T process asset library (ProPath).
- Develops and promotes forward-thinking IT strategy to help VA meet future mission requirements.
- Promotes and practices knowledge management concepts and best practices to improve information sharing across OI&T and with its customers.
- Performs analyses of alternatives to identify cost savings/avoidance.
- Examines existing processes, IT requirements and solutions for efficiency and potential redundancy (e.g., legacy system sun-setting) elsewhere in the organization.

Enterprise Architecture

Overview

The Office of Enterprise Architecture (OEA) leads the development of IT-related transformation strategies and plans and develops and maintains the VA's Enterprise Architecture (EA) to implement them. The Office collaborates closely with other strategic planners and architects within OI&T and across VA to ensure alignment of strategic and operational plans from enterprise, business and technology perspectives. It also provides liaison support with OMB and GAO on related activities.

The VA EA provides decision-support information capabilities to leaders and stakeholders across VA. It contains explicit description and documentation of the current and desired relationships among programs/ initiatives, business functions, processes, and the technology to support transformation, modernization and continuous improvement efforts. The VA EA is an authoritative reference, decision-support and management tool that facilitates strategic planning, resource management, forecasting, product development, delivery, and operation of VA's Business and Information Technology environments to ensure an affordable Veteran-centric and technology-enabled IT infrastructure. OEA maintains the VA EA in a centralized repository to provide visibility to all VA employees and support contractors and establishes the standards and taxonomies used in the VA EA to represent architectural content, relationships and linkages.

The planning function within this office collaborates with planners in other offices and directly assists the CIO and OI&T Executive Leadership to formulate and communicate an IT strategy that aligns with overarching VA strategic plans, business goals, and objectives. It leads the development of the

Enterprise Roadmap, the Information Resource Management Strategic Plan and IT strategic planning guidance. These critical documents identify, promote and enable VA enterprise and CIO priorities, and foster effective IT strategy formulation, resourcing, and execution activities to realize synergies and efficiencies among participating business components.

Functions and Activities

- Plan, develop, and maintain configuration control of the VA EA, which is a strategic information asset and decision support tool that defines VA's mission and the information and technologies needed to perform it.
- In collaboration with agency stakeholders, develop and publish the Information Resources Management Strategic Plan, Enterprise Roadmap and IT strategic planning documents to enable enterprise and business mission outcomes.
- Develop and execute a performance measurement management capability to monitor EA value and outcomes.
- Liaison with OMB on EA and IT strategic planning activities.

Technology Strategies

Overview

The Office of Technology Strategies (TS) develops the strategy, guidance, implementation and governance for VA's "to-be" technology environment. Its capability areas are driven by the VA CIO Goals and inform VA's Enterprise Roadmap (ERM), which support the overall VA mission and strategy to meet emerging business needs to better serve Veterans. TS help create and implement a more effective and efficient enterprise IT environment to meet business needs while maintaining a consistent approach to the System and Software Development Lifecycles (SDLC). Situated in the Office of Information and Technology's (OI&T) Architecture, Strategy and Design (ASD) Directorate, TS is organized around the following capability areas: IT Infrastructure Vision development and maintenance; enterprise design patterns; and governance, enforcement, assessment, and compliance (GEAC).

Functions and Activities

- TS is responsible for the Enterprise Technology Strategic Plan (ETSP), which defines the "to be" enterprise technology vision. This document reflects VA's IT vision attributes and describes how those attributes are driving VA toward a future in which Veterans, dependents, customers and partners receive seamless service experiences and increased access to information.
- TS develops Enterprise Design Patterns, which are designed as enterprise-level guidance documents that provide a reusable set of standards, policies and capability frameworks to enable VA to conduct standardized development, acquisition and/or implementation of IT systems and services.
- TS maintains the One-VA Technical Reference Model (TRM) which is one component within the overall EA providing coordinated and consolidated decisions from across OI&T and business lines on approved and unapproved technologies and standards within VA.

- TS focuses on supporting GEAC activities to ensure projects adhere to the VA Enterprise Technical Architecture (ETA) through oversight over the Architecture Engineering Review Board (AERB) Compliance Review, technical reviews, until PMAS is sunsetted, of all project documentation and artifacts, support for PMAS Milestone reviews and follow-up support to ensure compliance with VA's IT strategic direction.
- TS also partners with other OI&T pillars to maintain a sustainable eco-system of infrastructure and applications by refining and establishing compliance guidance that is leveraged within the AERB and PMAS review processes.
- TS and its partners also set expectations prior to integrated project team (IPT) formation to holistically addresses architecture requirements and set boundaries to constrain solution designs in a manner consistent with the ETA.

Other key TS functions of the future state include:

- Coordination across ASD service offerings to ensure architecture and engineering SME team formation necessary to guide solution designs that leverage the prescribed architecture.
- Provide expert design services for infrastructure-specific architectures (e.g. mobility, ESB, data center consolidation, shared security services, Cloud) for the VA Enterprise.
- Application of infrastructure solution architecture and platform management discipline throughout the SDLC as projects work to design, develop and deploy systems and products in accordance with VA business needs.
- Develop artifacts that will improve system flexibility, to include: infrastructure environment designs, data management environment designs, shared services strategy and IT Infrastructure Optimization Strategy.
- PMAS decision-making authority to ensure solution design compliance/readiness prior to deployment into the VA operating environment until PMAS has been sunsetted.
- Provide information to other PMAS Review voting members and to the general OI&T audience concerning a project's compliance with ASD requirements until PMAS has been sunsetted.
- Guide enterprise contract requirements to ensure investment decisions are made based on sufficient architectural consideration and technology roadmap guidance.
- Management of information concerning the VA Technology Strategy.
- Researches emerging and new technologies for applicability to VA, considering applicability and cost.
- Coordinates activities with OI&T pillars to drive consensus and a consolidated VA IT Vision.
- Perform alternative and technical trade-off analyses within infrastructure space.
- Build and maintain VA IT Infrastructure optimization (i.e. divestiture) plan.

- Provide subject matter expertise on Technology Strategies & Platform Management objectives to VA leadership.

Process and Knowledge Management and Communications Service

Overview

Process and Knowledge Management and Communications Service (PKMCS) has four primary mission areas: process management (PcM), knowledge management (KM), records management (RM) and communications service (CS). PcM is responsible for developing, implementing, updating, and overseeing the OI&T process asset library, for use in executing the business of OI&T. KM is responsible for the creation, discovery and sharing of ASD knowledge. RM is responsible to manage, protect, and retain ASD records in a manner that ensures timely and efficient availability and retrieval with a reasonable guarantee of authenticity and reliability. Lastly, CS informs the ASD workforce to promote a greater awareness and understanding of ASD plans, endeavors, products, and accomplishments.

The four PKMCS mission areas strive to improve organizational performance and informed decision making; promote efficient and effective collaboration, communications, and information sharing; enable business continuity; and deliver products and services valued by Veterans, partners, customers, and stakeholders.

Functions and Activities

Process Management

- Works with OI&T Subject Matter Experts to streamline business practices and publish frequent ProPath releases to make these process improvements available for use by the OI&T workforce.
- Leads continuous process improvement efforts and uses techniques such as Lean Six Sigma.
- Creates and executes organizational performance improvement plans.
- Engineers and implements standardized processes/procedures, artifacts, and tools .
- Educates and assists staff on the use of the processes and tools to make organizational performance gains.

Records Management

- Develops materials and tools to standardize the management of electronic federal records.
- Maintains the ASD file plan and inventory; approves the disposition of federal records.
- Evaluates new records for addition into the records schedule.
- Sets policies and practices for effective and compliant records management.
- Collaborates with records management programs VA-wide to share records management information and resources.

Knowledge Management and Communications Service

- Manages and administers ASD's Internet, intranet, and SharePoint sites.
- Establishes the methods to acquire, use, transfer, and retain ASD knowledge to inform decision making and support business continuity.
- Promotes and practices knowledge management best practices to improve information sharing across OI&T and with its customers.
- Sets policies and practices for effective knowledge management and internal communication within ASD.
- Oversees the development and use of ASD's Meta-Knowledge Repository (MKR).

ASD Business Office

Overview

The ASD Business Office (ABO) plans, develops, coordinates, and manages essential business, administrative, and logistical **Functions and Activities** of ASD. ABO coordinates directly with the OI&T Front Office and ASD subordinate offices, as well as with offices and organizations VA-wide; other federal departments and agencies; and non-governmental organizations as required and appropriate.

Functions and Activities

ABO's areas of responsibility include:

- Fiscal planning.
- Programming, budgeting, and execution oversight.
- Executive correspondence.
- Tasking, action, and reports management.
- Emergency and contingency planning and operations.
- Special project coordination.
- ASD policy, guidance, and standard operating procedures.
- Human capital management.
- Personnel administration and actions.
- Employee training.
- Facilities and space management.
- Supplies, IT assets, equipment, and property management.

- Acquisition and contract management and oversight.

Authorities

Information Technology Management Reform Act of 1996 Title 40
 Information Technology Management Reform Act (Clinger-Cohen Act) of 1996
 Federal Information Technology Acquisition Reform Act (FITARA) – HR. 1231
 E-Government Act of 2002
 Federal Information Security Management Act 2002 (FISMA)
 The Federal Records Act of 1950 (44 US §3101)
 The Freedom of Information Act, as amended 5 U.S.C. 522
 GAO Enterprise Architecture Management Maturity Framework (Version 2.0) (Aug 2010)
 The Government Paperwork Elimination Act of 1998
 The Government Performance Results Act (GPRA) of 1993
 GPRA Modernization Act of 2010
 Government Management Reform Act (GMRA) of 1994
 National Institute of Standards and Technology (NIST) Special Publication 800-37- NIST SP 800-37:
 Computer Security
 OMB Circular A-11
 OMB Circular A-123, Management’s Responsibility for Internal Control
 OMB Circular A-130, Management of Federal Information Management Resources
 OMB’s Common Approach to Federal Enterprise Architecture
 OMB Memorandum M-10-06, Open Government Directive
 OMB Memorandum, M-11-29, Chief Information Officer’s **Authorities**
 OMB Memorandum, M-13-13, Open Data Policy – Managing Information as an Asset
 OMB Memorandum, M-14-03, Enhancing the Security of the Federal Information and Information
 Systems
 OMB Memorandum, M-15-01, FY2014-15 Guidance on Improving Federal Information Security and
 Privacy Management Practices
 OMB Memorandum, M-15-14, Management and Oversight of Federal Information Technology
 OMB Memorandum, M-16-03, FY2015-2016 Guidance and Federal Information Security and Privacy
 Management Requirements
 OMB Memorandum, M-16-04, Cybersecurity Strategy and Implementation Plan (CSIP) for the Federal
 Civilian Government
 U.S.C. 44 § 3506
 VA Directive 6051 – Enterprise Architecture (12 Jul 2002)
 VA Directive 6052 – VA Information Technology Strategic Planning (23 April 2009)
 VA Directive 6102 – Internet/Intranet Service (15 July 2008)
 VA Directive 6371
 VA Directive 6300
 VA Directive 6301
 VA Directive 6404 – VA Systems Inventory (VASI) (23 Feb 2016)
 VA Directive 6500 – Information Security Program (20 Sep 2012)
 VA Directive 6518 – Enterprise Information Management (20 Feb 2015)
 36 CFR Part 1220 - FEDERAL RECORDS; GENERAL
 OIT Records Control Schedule (RCS) 005-1
 VHA RCS 10-1
 VBA RCS VB-1
 VHA Handbook 6300.1

Office of IT Account Manager (Corporate)

Overview

The IT Account Management (ITAM) office reports to the CIO and is responsible for the creation and management of the business partners' portfolios. The ITAM organization consists of account managers for Health, Benefits, and Corporate (includes VACO & NCA). IT Account Managers (ITAMs) are dedicated to addressing the customers' needs. ITAM helps to identify and define innovative solutions that meet the customers' needs and will present those interests directly to the CIO. The ITAMs interface directly with Administrations and Staff Offices and serve as lead portfolio requirements managers. They provide invested, real-time strategic leadership on issues like portfolio balancing and service delivery, providing a unifying force between the business partners and the Enterprise Program Management Office team. ITAMs act as the primary conduit between OI&T and the business partner, interface with industry, and serve as a catalyst to drive innovation. ITAMs work as a team to continuously evolve and improve the way OI&T enables its world-class business partners in their delivery of Veteran care and benefits. By working with Customer Relationship Managers (CRMs), who serve as technical IT leads with responsibility for product and resource management and service delivery, ITAMs will collect data about OI&T performance nationwide. This information will, in turn, provide OI&T with a better approach to issue resolution, change management, and Enterprise innovation.

Functions and Activities

- Responsible for interfacing between OI&T and its partners with respect to issue identification and resolution.
- Supports issue resolution by providing facilitation and coordination services between OI&T and its customer base.
- Provides facilitation and coordination functions that create and maintain open channels of communications between OI&T and its customers, thus enabling greater awareness of customer issues, which will facilitate meaningful engagements that result in the resolution of partner issues.

Office of IT Account Manager (Health)

Overview

The IT Account Management (ITAM) office reports to the CIO and is responsible for the creation and management of the business partners' portfolios. The ITAM organization consists of account managers for Health, Benefits, and Corporate (includes VACO & NCA). IT Account Managers (ITAMs) are dedicated to addressing the customers' needs. ITAM helps to identify and define innovative solutions that meet the customers' needs and will present those interests directly to the CIO. The ITAMs interface directly with Administrations and Staff Offices and serve as lead portfolio requirements managers. They provide invested, real-time strategic leadership on issues like portfolio balancing and service delivery, providing a unifying force between the business partners and the Enterprise Program Management Office team. ITAMs act as the primary conduit between OI&T and the business partner, interface with industry, and serve as a catalyst to drive innovation. ITAMs work as a team to continuously evolve and improve the way OI&T enables its world-class business partners in their delivery of Veteran care and benefits. By working with Customer Relationship Managers (CRMs), who serve as technical IT leads with responsibility for product and resource management and service delivery, ITAMs will collect data about

OI&T performance nationwide. This information will, in turn, provide OI&T with a better approach to issue resolution, change management, and Enterprise innovation.

Functions and Activities

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- Supports issue resolution by providing facilitation and coordination services between OI&T and its customer base.
- Provides facilitation and coordination functions that create and maintain open channels of communications between OI&T and its customers, thus enabling greater awareness of customer issues, which will facilitate meaningful engagements that result in the resolution of partner issues.

Office of IT Account Manager (Benefits)

Overview

The IT Account Management (ITAM) office reports to the CIO and is responsible for the creation and management of the business partners' portfolios. The ITAM organization consists of account managers for Health, Benefits, and Corporate (includes VACO & NCA). IT Account Managers (ITAMs) are dedicated to addressing the customers' needs. ITAM helps to identify and define innovative solutions that meet the customers' needs and will present those interests directly to the CIO. The ITAMs interface directly with Administrations and Staff Offices and serve as lead portfolio requirements managers. They provide invested, real-time strategic leadership on issues like portfolio balancing and service delivery, providing a unifying force between the business partners and the Enterprise Program Management Office team. ITAMs act as the primary conduit between OI&T and the business partner, interface with industry, and serve as a catalyst to drive innovation. ITAMs work as a team to continuously evolve and improve the way OI&T enables its world-class business partners in their delivery of Veteran care and benefits. By working with Customer Relationship Managers (CRMs), who serve as technical IT leads with responsibility for product and resource management and service delivery, ITAMs will collect data about OI&T performance nationwide. This information will, in turn, provide OI&T with a better approach to issue resolution, change management, and Enterprise innovation.

Functions and Activities

- Responsible for interfacing between OI&T and its partners with respect to issue identification and resolution.
- Supports issue resolution by providing facilitation and coordination services between OI&T and its customer base.
- Provides facilitation and coordination functions that create and maintain open channels of communications between OI&T and its customers, thus enabling greater awareness of customer issues, which will facilitate meaningful engagements that result in the resolution of partner issues.

IT Resource Management

Overview

The OI&T Resource Management (ITRM) advises the CIO and other senior OI&T officials on OI&T resource requirements. The office is responsible for the management of all IT resources, direction of financial and IT asset management, and the policies and strategic planning activities for OI&T acquisitions. With primary responsibility for linking the budgeting process with IT programs, ITRM is responsible for directing fiscal activities related to linking the budget process to all established IT operations and enterprise-wide management initiatives. Offices within the organization include IT Budget and Finance; IT Acquisition Strategy and Facilities Management.

IT Budget and Finance

Overview

The Office of IT Budget & Finance's (ITBF) mission is to plan, program, execute, control, and account for VA's IT resources. ITBF is responsible for the establishment, implementation, and oversight of the concepts, plans, policies, systems, and procedures required to execute the assigned mission. ITBF in concert with VACO Staff Offices is responsible for establishing and managing the Department's IT governance structure and determining the appropriateness and applicability (through interpretation of fiscal law) of the use of the IT appropriation. ITBF plans, executes, and oversees the Department's IT budget in order to meet all IT requirements across VA in alignment with its missions, goals, and objectives. Management of the annual IT budget that meets the IT resource requirements for more than 300,000 employees spanning the three administrations and staff offices are unique to ITBF, as no other organization in VA is authorized to execute the funds allocated through the IT appropriation. ITBF resource stewardship and OI&T systems delivery also touches every aspect of meeting VHA, VBA, NCA and staff offices' mission needs in support of more than 300 hospitals and facilities supporting more than 8.5 million enrolled Veterans.

IT Programming and Budget Formulation Service

Overview

The information technology resource cycle begins with the IT multi-year Programming and Budget Formulation Service (ITPBFS). ITPBFS leads the orchestration, formulation, and advocacy of approximately \$4 billion annually and some \$20 billion in the multi-year budget request through the VA governance structure, OMB reviews, and Congressional enactment phases. ITPBFS also functions as the OI&T interface to the VA corporate governance structure and leads integration of the Planning, Programming, Budgeting and Execution Board (PPBE) into the larger VA governance structure.

Functions and Activities

- Directs IT Multi-Year Programming Process.
- Orchestrates the activities of PPBE Board and integrates departmental priorities.
- Ensures alignment of IT Portfolio Structure to VA mission, goals, and objectives and priorities.
- Develops and issues annual programming guidance, to include Defining Funding Targets, Resource Bands, and Unfunded Requirements Process.

- Directs the annual budget formulation process.
- Develops internal VA budget, submission and presentation to SECVA.
- Leads OMB Pass back process and develops Congressional Budget Submission.
- Supports Congressional Enactment Phase (SECVA defense of the IT Budget).

IT Budget Execution and Analysis Service

Overview

The IT Budget Execution and Analysis Service (ITBEAS) is responsible for translating the Congressionally approved budget top-line numbers into an executable budget operating plan that ensures IT funds are appropriately and fully aligned to fund the development, sustainment, and staffing needs across the enterprise. ITBEAS also functions as centralized systems and analysis organization, and ensures integration of information contained in the annual Budget Operating Plan (BOP) with VACO staff offices supporting acquisition, logistics, and policy development and implementation.

Functions and Activities

- Develops the Program-Budget Business Process, to include management of and participation in the Business Intake Processes and budget management controls.
- Develops the BOP, to include Program-Budget Baseline Control Points, and Congressional reporting requirements .
- Executes the program-budget as allocated across the fund accounts to include obligations to meet development, operations and sustainment, and staffing requirements across the OIT enterprise.
- Orchestrates the sustainment and enhancements to the Budget Tracking Tool (BTT), to include incorporation and interfaces to VA acquisition and financial management .
- Chairs the Executive Steering Committee (ESC) and Change Control Board (CCB).
- Provides oversight of program-budget composition and execution status, identifies anomalies, and recommends areas for improvement.
- Identifies program-budget development reasonableness and execution risk.
- Performs selected analysis on programmatic resource requirements and allocation at centralized and site-specific locations.

IT Financial Management and Oversight Service

Overview

The IT Financial Management and Oversight Service (ITFMOS) completes the cycle providing a full accounting of all budgetary resources and ensuring internal controls across all resource activities throughout the OI&T enterprise.

The ITFMOS serves as the accounting and financial policy interface to the Department, oversees the IT Travel and Purchase Card Policy, and serves as the Department's lead on IT Internal Controls and meeting the Federal Managers Financial Integrity Act (FMFIA) responsibilities. To that end, the objective of the Internal Controls Branch is to evaluate OI&T risks and provide a level of assurance that OI&T achieves effectiveness and efficiency of operations, reliability of financial reporting, and compliance with applicable laws and regulations.

Functions and Activities

- Serves as the accounting and financial policy interface to the Department's Office of Finance, and monitors and reports on OIT financial management compliance with all applicable federal and financial laws and regulations.
- Provides guidance and analysis on all aspects of financial management, audit readiness and remediation, and directs and manages OIT's financial operations and systems support in an integrated manner to support the VA's overall mission needs and the SECVA's strategic goals.
- Supports development of VA's central payroll and human resources system-the VA Time and Attendance System (VATAS) - and the OIT cost accounting dashboard for the VA's System to Drive Performance (STDP).
- Provides data, analysis and reporting using VA's corporate core accounting system-the Financial Management System (FMS) - the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system (IFCAP), the Financial Reports System (FRS) and the Management Information Exchange System (MinX).
- Develops and implements a structured OIT-wide Internal Controls Program for the purpose of establishing a robust internal controls framework in accordance with VA requirements, OMB timelines and all applicable laws and regulations.
- Leads the OIT assessment, testing, evaluation and reporting of the status of OIT internal control systems' performance and accountability.
- Develops and implements OIT-wide internal controls training and communications processes to include formulation of senior leadership boards of governance.
- Manages the OIT Travel and Purchase Card program's adherence to existing policy and laws, and implements VA Travel and Purchase Card policy changes as they occur.

IT Acquisition Strategy and Space/Facilities Management

Overview

IT Acquisition Strategy and Facilities Management have three divisions: (1) IT Acquisition Strategy, (2) IT Space and Facilities Management and, (3) IT Vendor Management Office.

IT Acquisition Strategy Office

Overview

The IT Acquisition Strategy Office supports the OI&T acquisition process by facilitating the governance of clear, consistent, and well developed acquisition processes and strategies. This office provides acquisition program management oversight, acts as industry liaison, provides customer interface support (i.e., Service, Delivery & Engineering, Product Development, and Office of Information Security), disseminates acquisition policy and procedures, and monitors OI&T Federal interagency agreements and processes. Other key functions of this office include serving as a strategic partner for internal and external customers while providing centralized oversight for all OI&T procurement actions valuing in over \$3 billion annually; supporting the VA acquisition systems and participating in change control boards for acquisitions. Specific systems supported by the office include: IT Acquisition Requirements System (ITARS), Budget Tracking Tool (BTT), Virtual Office of Acquisition (VOA), and Enterprise Contract Management System (ECMS).

Functions and Activities

- IT Acquisition Core Processes/Services, Manage ITARS, Customer liaison OI&T.
- Attend OI&T Acquisition Support meetings and Monthly Performance Report.
- Acquisition Planning & Integration, Contracts Administration- both COTR duties /development of new acquisition packages.
- APB Improvement (Pro Path), Acquisition Support tools, BTT, and VOA synchronization (budget reports).
- FITARA Lead for OI&T, Support Strategic Initiatives (to include SEWP/CEC) OMB requirements Category Management efforts.
- Acquisition Management & Oversight and Liaison with TAC/customers (OI&T).
- Develop Policies/Procedures for OI&T acquisition actions and Support OI&T/ITRM Special Projects.
- Support Acquisition Analysis and Support Contractor Onboarding.

IT Space and Facilities Management Office

Overview

The IT Space and Facilities Management Office advises and provides oversight and guidance in OI&T national program areas of real property, facility management, space management, construction

management, occupational safety and health, energy management and physical security to OI&T senior leadership; serves as the OI&T representative to the VA Strategic Capital Investment Planning (SCIP) process, including major and minor construction projects needed to address IT infrastructure deficiencies across the VA enterprise; and is responsible for developing national long-term and short-term strategies for the optimal utilization and management of OI&T data centers, computer rooms, workspaces, and in effectively managing day-to-day facility-related activities. The office is also responsible for maintaining more than 1.2 million square feet of leased and owned space for the VA's data centers and over 9,000 OI&T employees and contractors nationwide.

Functions and Activities

- Oversight and guidance in OI&T National Areas of Real Property.
- Maintain OI&T leased and owned properties.
- Manage OI&T data centers.
- Represent OI&T in VA Strategic Capital Investment Planning (SCIP) Process.
- Contract Service.

IT Vendor Management Office

Overview

The IT Vendor Management Office is an added function directed by the VA CIO as mandated by the Federal Chief Information Officer and the Office of Management and Budget. Additional support services include developing policies and procedures related to OI&T strategic sourcing and vendor management operations as well as serves as the “front door” for all vendors who are doing business and those who are seeking to do business with OI&T. The IT Vendor Management Office also assists OI&T in providing solutions to complex enterprise capabilities and serves as the OI&T Small Business representative within the organization for all socioeconomic categories.

Functions and Activities

- Coordinate Vendor Engagements that supports congressional inquiries, and directed engagements.
- Conduct Vendor Analysis to support strategic sourcing initiatives.
- Manage Green Procurement (EPEAT).
- Coordinate Vendor Briefings to OI&T customers/requirement holders for situational awareness.
- Support OI&T/VA vendor assignments.
- Market Research (Customers).
- Supervisory administrative duties and DSR Report.

Office of the Chief Learning Officer

Overview

The Office of the Chief Learning Officer (CLO) is responsible for providing executive leadership in the formulation, implementation, and management of a comprehensive employee, leadership, and organizational development and training program for OI&T.

Functions and Activities

- Engage key agency stakeholders as well as other senior and line managers to ensure learning opportunities are innovative and relevant to mission needs, focused on enhanced performance, and provide a positive return on agency investment.
- Ensures employees and leaders are technically proficient, effectively oriented to OI&T's mission, vision and values, and understand their role in and linkage to the delivery of services to the Nation's Veterans.

IT Workforce Development

Overview

IT Workforce Development (ITWD) is located within the Office of the CLO provides OI&T-wide learning initiatives and strategies that support OI&T's ability to create and maintain a high-performing workforce to serve our Nation's Veterans. ITWD prepares VA IT professionals to better serve Veterans and achieve personal career goals through the delivery of targeted, competency based skills, and development programs.

Functions and Activities

- Design, develop, and deliver IT specific training to the OI&T workforce using various modalities.
- Provide industry recognized IT certification courses in strategic locations across OI&T including VA National IT Training Academy (NTA) headquarters and Smart Classrooms.
- Administer the NTA Smart Classroom network's three facilities across the United States capable of hosting synchronous training courses.
- Implement and maintain competency models in OI&T using the Office of Personnel Management (OPM) framework. ITWD coordinates the validation of each parenthetical role (e.g., ISO, Software Developer) with VA SMEs and then implements the model in the VA Talent Management System (TMS).
- Provide FISMA compliance, privacy, and rules of behavior training for the VA.

Project Managers of Technology

Overview

Project Managers of Technology (PROMOTE) is located within the Office of the CLO uniquely prepares veteran participants for a successful transition into a career as an information technology specialist and

project manager within OI&T. Participants become trusted business partners capable of exercising sound business judgment to achieve best value IT solutions that serve both internal VA customers and Veterans.

Functions and Activities

- Implement a training program that focuses on professional development opportunities that brings participants quickly through entry and mid-level Federal Acquisition Certification for Program and Project Managers (FAC P/PM) certification standards.
- Provide leadership training, business skills, practical application exercises and real world project/program management experience.

Measure, Quality, and Outreach

Overview

Measures, Quality, and Outreach is located within the Office of the CLO assists in creating an environment where engagement between managers and employees allows job learning to flourish. Employee development remains a primary enabler for IT success through Talent Management.

Functions and Activities

- Participates in workforce planning to analyze IT needs relating to support requirements, predicting competencies, and the process of hiring appropriately.
- Perform knowledge management by analyzing retirement eligibility, propensity to retire, and training to replace due to losses, which assists in providing stronger succession planning.
- Provide survey follow-up for analysis and action planning.
- Computes effectiveness, efficiency, and outcome measures for the CLO office to track progress toward annual goals and objectives.
- Performs quality assurance of learning solutions to ensure applicability and effectiveness of educational products.

Office of Information Security

Overview

The Office of Information Security (OIS) provides information security and privacy infrastructure for VA. The office assures the confidentiality, integrity, and availability of information and information systems, and works on matters related to information protection, including privacy, cyber security, risk management, incident response, critical infrastructure protection, and business continuity. In addition, the OIS team develops, implements, and oversees the policies, procedures, training, communication, and operations related to improving how VA and its partners safeguard the personally identifiable information (PII) of Veterans and VA employees.

Functions and Activities

- Protect the overall VA information security posture to ensure confidentiality, integrity, availability, and appropriate destruction of information.
- Integrate risk and performance management into information security and privacy practices to create a cost and process effective program.
- Establish an Information Security governance structure and policies that create operational efficiency and accountability.
- Seamlessly integrate security processes into VA's business and IT projects to reduce exposure to risk and maximize efficiency.
- Promote an environment where all employee's and contractor's actions reflect the importance of information security accountability.

OIS Front Office

Overview

OIS Front Office staff is responsible for overseeing the composition of executive-level correspondence, preparation of congressional testimony, and speeches and responses to public relations inquiries. The Front Office also manages OIS performance reporting within OI&T as well as the VA and external stakeholders such as the OMB.

Functions and Activities

- The Communications Team is responsible for a range of communication duties including executive messaging, regular department newsletters, and awareness campaigns within OIS.
- The Communications Team also provides weekly and monthly performance reports to internal and external stakeholders—e.g., Congress, VA CIO.
- The Correspondence Team oversees all Veterans Affairs Internet Quorum (VAIQ) items and executive correspondence actions within OIS.
- The Correspondence Team also manages responses to GAO and Inspector General inquiries, studies, and reports.

OIS Business Office

Overview

The OIS Business Office performs business management functions required to support the office's initiatives and programs. The Business Office also interprets acquisition regulations, laws, and VA policy that govern security for IT acquisitions, and confirms that all IT and non-IT products and services connecting to the VA network, or that have the potential to store sensitive data, are documented and approved.

- The Budget Team is responsible for the formulation, execution, and development of the multi-year plan of the OIS budget.

- The Contract Management Team serves as the liaison between OIS and acquisition staff, both internal and external to VA. Information Technology Acquisition Request System (ITARS) Support ensures security requirements are included in IT acquisition contracts, and Virtual Online Acquisitions (VOA) helps the team manage contracts and monitor data.
- The Human Resources Team completes human resources duties for all of OIS. These responsibilities include staffing, financial awards, and service recognition, among others.

Functions and Activities

- Provide Acquisition Support.
- Provide Budget Execution & Formulation Support.
- Provide Communications Support.
- Provide Executive Correspondence Support.
- Provide Facilities Management Support.
- Provide HR Support.
- Provide IT Support.
- Provide Performance Management Support.
- Provide Programming & Planning Control (PPC) Support.

Field Security Service

Overview

The mission of the VA Office of Information Security (OIS)/Field Security Service (FSS) is to ensure the privacy, confidentiality, integrity, and availability of VA information assets associated with the services offered by the Department of Veterans Affairs. In addition, FSS provides assurance that cost effective security controls are in place to protect automated systems from financial fraud, waste, and abuse. Field Security Service (FSS) primarily consists of VA Information Security Officers (ISOs). Geographically dispersed throughout the Department, FSS ISOs are the “boots on the ground” security professionals, the face of information security for the Department. FSS is organized into three divisions – ISO Division, Health Information Security Division (HISD), and Data Center Support Division (DCSD).

Functions and Activities

- Information Security Officers Support - FSS provides Information Security officers support to all VA field facilities and all OIT development products and projects. ISOs provide information security expertise and support to ensure VA systems and applications are in compliance with federal and VA laws and regulations.
- Health Information Security Division (HISD) - The Field Security Service (FSS) Health Information Security Division (HISD) ensures the privacy, confidentiality, integrity, and availability of networked medical devices in order to uphold the world class patient care that Veterans and

their beneficiaries expect from VA. Through a collaborative team approach, HISD develops, evaluates, and implements a cost-effective security program to protect networked medical devices, telehealth systems, VHA Research and all critical infrastructure systems connected to VA's enterprise network. HISD also manages the National Contractor Access Program which is an access methodology necessitated from companies needing single secure login into the VA network for employees to support multiple facilities. The program supports two options for secure access to the VA network: 1) National Client to Site VPN Accounts; 2) National Site to Site VPN Tunnels. HISD has also been given responsibility to oversee all VA ISA/MOUs, providing subject matter expertise, guidance and quality reviews for all external connection.

- **Data Center Support Division (DCSD) - The Field Security Services (FSS) Data Center Support Division (DCSD)** supports the National Data Center Program (NDCP) - a VA OIT initiative to consolidate all VA enterprise and mission critical systems into National Data Centers (NDC's). FSS DCDS provides proactive, best-in-class security expertise that ensures the confidentiality, integrity, and availability of information for innovative projects, complex systems and essential programs within the VA enterprise and national data centers.

ISO Division

Overview

ISO Division provides ISO support to all VACO, VHA, VBA, NCA, and program offices. This is the largest division and is further broken down into five regions, each led by a Regional Information Security Director. ISOs are agency officials assigned with the responsibility to ensure that the appropriate operational security posture is maintained for an information system or program.

ISOs administer the VA Information Security Programs at VA facilities, ensuring compliance with federal security requirements and VA security policies. They also ensure that cost-effective security controls are in place to protect automated systems from fraud, waste, and abuse. FSS ensures the privacy, confidentiality, integrity, and availability of information assets in facilities and field offices across the country.

Functions and Activities

- **VA Network Access / Remote Access** - FSS ISOs verify and audit that information system users go through a security screening, completed Security and Privacy Awareness Training, and signed the VA Rules of Behavior.
- **Incident Reporting** - ISOs help to protect of Veteran data by ensuring information security incidents are properly reported and problems remediated.
- **Media Protection, Sanitization, and Disposal** - ISOs ensure that those who handle VA media understand the policies for protecting the information contained within it. Properly sanitizing and disposing of media prevents loss of personally identifiable information (PII) or patient health information (PHI) and minimizes the risk for a data breach.
- **Assessment and Authorization** - ISOs assist in the evaluation, testing, and authorization of controls that minimize security risks to VA IT systems and information. All VA IT systems and applications are "assessed and authorized" before they can be used.

- Continuous Monitoring - ISOs participate in the ongoing monitoring of VA information systems to help minimize risk to these systems. Continuous monitoring helps the VA's core mission and business functions.
- Medical Device Security - ISOs support the FSS HISD division and play an active role in communications, training, and IT risk management activities designed to safeguard medical devices from cyber threats.
- Information Security in Research - ISOs work with business partners to review proposed research studies. This review process ensures compliance with information security policy and federal regulations.
- Information Security in Contracts - ISOs participate in the review of contracts to ensure adequate information security and privacy measures are included in all potential IT acquisitions.

Health Information Security Division (HISD)

Overview

Health Information Security Division (HISD) supports two national information security programs – the Medical Device Protection Program and the National Contractor Access Program.

Functions and Activities

- Special Purpose Systems Security Program.
- HISD ISOs are responsible for the development and implementation of a comprehensive security program that will govern VHA Research and all critical infrastructure systems (HVAC, Energy Management, Policy Surveillance, etc.) across the enterprise. This program will address security throughout the life cycle of these systems.
- Interconnected Systems Agreements and Memorandums of Understanding (ISA/MOU) oversight.
- HISD staff is responsible for providing subject matter expertise, guidance and quality reviews for all external connection to the VA enterprise.

Medical Device Protection Program

Overview

The Medical Device Protection Program (MDPP) is a comprehensive security initiative for the safe and secure operation of network connected medical devices and telehealth systems. The program encompasses pre-procurement assessments, medical device isolation architecture, communications, training, validation, scanning, remediation, patching, and secure remote connectivity. HISD provides MDPP guidance to ISOs, Biomedical Engineers, and OI&T personnel. In addition to internal VA collaboration, HISD partners with external stakeholders across the federal government and the medical device industry to share best practices and better safeguard medical devices from threats.

Functions and Activities

- **Communication & Training** - HISD ISOs are responsible for all communication and training related to VA's Medical Device Protection Program. Communicate clearly the vision, the mission, and the objectives of MDPP through timely and appropriate generation, collection, distribution of program information. Utilize multiple channels, including speaking, writing, video, training, focus groups, bulletin boards, and Intranet, for successful communications that guide the program, stakeholders, customers, and sponsors to an understanding of the entire program. Provide training opportunities to support the implementation of new initiatives and for the sustainment of the overall program. Training is a critical element and high quality training bolsters a team's ability to ramp-up on required skills and deploy the new practices quickly and effectively.
- **Risk Assessment and Evaluation Program** - HISD ISOs provide enterprise guidance and process for all elements of the MDPP risk framework, which includes; working with assessment offices within the VA to conduct independent reviews that will reflect the status of compliance and effectiveness of process, people, and tools implemented through the program; provide monitoring of MDPP security controls to ensure they are in place and functioning as intended and develop enterprise security controls documentation and risks assessments that support MDPP.
- **Incident Response** - HISD ISOs provide incident response capability for the enterprise when a medical device is suspected of being infected. HISD ISOs, local Biomedical Engineering staff, in conjunction with medical device vendors, must expedite the reporting and response to compromised medical devices in order to prevent alteration of the function of or availability of the medical device.
- **Healthcare Industry Participation** - HISD ISOs are responsible for developing partnerships with external stakeholders across the federal government and the medical device industry to share best practices and develop a safer biomedical device network across the healthcare industry.

National Contractor Access Program

Overview

The National Contractor Access Program (NCAP) is an access methodology necessitated from companies needing single secure login into the VA network for contractors to support multiple VA facilities. The program supports two options for secure access to the VA network - National Client to Site VPN Accounts and National Site to Site VPN Tunnels.

Functions and Activities

- **National Client to Site VPN Accounts** - HISD ISOs process and maintenance all national client to site VPN accounts for contractors that require access to multiple facilities across the enterprise.
- **National Site to Site VPN Tunnel** - HISD ISOs establish, process and maintenance national site to site VPN tunnels, working with local business lines and ISOs in completing ISA/MOUs in cooperation with the outside vendor, processing the request for connection and maintaining the documentation over the life of the connection.

Data Center Support Division

Overview

The Data Center Support Division (DCSD) administers the information security programs throughout the Enterprise Operations (EO) Information Technology Centers (ITC), Regional Data Centers (RDC), the Network Security Operations Center (NSOC), the Capital Region Readiness Center (CRRC) and VA enclaves within the Verizon Terremark facility to ensure the security of VA interagency systems, external partnerships, evolving technologies, and developing electronic initiatives.

DCSD ISOs maintain common controls across the data centers; provide Assessment and Authorization support to EO Security Services and Field Security Service ISOs; partner with internal and external partners to interpret and establish consistent security guidance; and centralize and standardize account management, network access control, database security, vulnerability scanning and remediation, and all other information security initiatives across the Information Technology Centers. DCSD ISOs maintain expertise through continued security education, training, and research, while sharing those lessons throughout the security community.

Functions and Activities

- Support the Federal Data Center Consolidation Initiative (FDCCI) - The Federal Data Center Consolidation Initiative (FDCCI) was launched in February 2010 by the Federal CIO Council, a government-wide Data Center Consolidation Task Force, to eliminate 800 federal data centers.
- Provide information security service to Federal Risk and Authorization Management Program (FedRAMP) The Federal Risk and Authorization Management Program (FedRAMP) is a government-wide program that provides a standardized approach to security assessment, authorization, and continuous monitoring for cloud products and services. Each Executive department or agency shall use FedRAMP when conducting risk assessments, security authorizations, and granting ATOs for all Executive department or agency use of cloud services.
- Assessment and Authorization - ISOs assist in the evaluation, testing, and authorization of controls that minimize security risks to VA IT systems and information. All VA IT systems and applications are “assessed and authorized” before they can be used.
- Continuous Monitoring - ISOs participate in the ongoing monitoring of VA information systems to help minimize risk to these systems. Continuous monitoring helps the VA’s core mission and business functions.
- Information Security in Contracts - ISOs participate in the review of contracts to ensure adequate information security and privacy measures are included in all potential IT acquisitions.

Office of Business Continuity

Overview

The Office of Business Continuity (OBC) is responsible for developing and implementing emergency management and continuity programs that ensure resiliency of critical IT tasks. BC develops implements and oversees policies, procedures, training, communications, and operations designed to ensure the continuity of the entire VA IT network of systems that store, process, and disseminate information that supports VA services to veterans and their families. In addition, BC provides staffing to VA’s Integrated

Operations Center to create and maintain shared situational awareness across administrations and staff offices concerning OI&T issues.

Functions and Activities

- Coordinates continuity planning and all-hazards emergency preparedness within OI&T.
- Assist and advise DAS/DCIO and their staff in meeting continuity planning and preparedness responsibilities.
- Serve as OI&Ts Emergency Coordinator, being the single point of contact for all emergency preparedness matters, including continuity.
- Serve as the primary point of contact for OI&T on all-hazards emergency alert/activation.
- Provide situational awareness on the accountability of OI&T personnel, ability of OI&T to execute its MEF/critical tasks, and IT incident response.

Office of Cyber Security Policy and Compliance

Overview

The Office of Cyber Security Policy and Compliance (CSPC) establishes policy and oversees the implementation and operation of IT security programs across the Department. CSPC oversees, manages, and directs all activities for audit resolution and readiness, the Certification Program Service, security architecture and software assurance, the Emergency Response team, and identity access management.

Functions and Activities

- Conduct accreditation and authentication processing.
- Provide cyber security policy support.
- Provide security architecture support.
- Provide software assurance services.
- Provide threat identification and analysis.

Enterprise Cybersecurity Strategy Team (ESCT): Tactical

Overview

In response to the Material Weakness (MW) in information technology identified during the Office of Inspector General (OIG) FY15 Federal Information Security Modernization Act (FISMA) audit, VA developed Plans of Action (POAs) addressing the full scope of the 35 recommendations. The Enterprise Cybersecurity Strategy Team (ECST) is providing oversight for an ECST Tactical team working to coordinate remediation activities within the broader OI&T Transformation effort. The ECST has established an aggressive schedule of remediation that will lead to the elimination of the IT Material Weakness by the end of CY2017.

Functions and Activities

- ECST Tactical team funding will be applied to a support contract that will bring the additional staff and resources needed to resolve security vulnerabilities and weaknesses.
- ECST Tactical contractors will performance a large set of day to day on-site security operations processes. These include: installing critical security patches to resolve weaknesses in VA software and applications, assisting with security audit log analysis, conducting security incident forensics investigations, updating security plans and other security documents, and performing security controls implementation, monitoring, and testing.
- Staff will work with performance measure goals that include resolving over 90% of all critical and high security vulnerabilities identified each month by vulnerability scans conducted by the Department of Homeland Security and VA's Network and Security Operations Center (NSOC).
- Other performance measure improvement targets include the updating of 95% of contingency plans, disaster recovery plans, and other security documentation as required by FISMA.
- In FY 2015, support efforts resulted in the delivery of an effective vulnerability and patch management program that will ensure that at least 90% of any identified vulnerabilities in VA systems are patched and remediated in a timely manner.

VA Enterprise Cybersecurity Strategy Team (ECST): Strategic

Overview

The VA Enterprise Cybersecurity Strategy & Implementation Plan (VA-ECSIP) defines the comprehensive set of actions, processes, and emerging security technologies that will further enhance the cybersecurity of VA's information and assets and improve the resilience of VA networks. VA-ECSIP is aligned with the Federal government-wide cybersecurity strategy efforts and was developed to identify and address critical cybersecurity gaps and priorities, with specific recommendations to address those gaps and priorities. The VA will resolve any remaining issues that have resulted in VA's material weakness condition in cybersecurity.

Functions and Activities

- Achieve compliance with the requirements of the Trusted Internet Connections (TIC) initiative to include achieving the performance measure targets specified for consolidating all network traffic behind a TIC.
- Implement Continuous Diagnostics and Mitigation (CDM) Phase 1 with an emphasis on achieving full accountability for all IT assets connected to the VA network.
- Implement two factor authentications for all remote access requirements and enable all privileged users to use the PIV card in the performance of system administration functions.
- Implement effective protection activities to include reducing the attack surface and complexity of VA's IT infrastructure.
- Safeguard data at rest and in-transit.

- Train personnel.
- Ensure repeatable processes and procedures.
- Adopt innovative and modern technology.
- Ensure strict domain separation of critical/sensitive information and information systems.
- Ensure a current inventory of hardware and software components.

Security Reports & Oversight Management Service

Overview

Security Reports & Oversight Management ensures that IT systems security in VA is managed in a manner that is compliant with all federal laws, regulations, and guidelines governing IT security; and ensures that Congress, OMB, GAO, OIG, and other OCS stakeholders are informed about VA's cyber security posture and associated risk. This organization also ensures that products and services purchased by VA are compliant with the Department's security requirements. The mission of this group is accomplished through the management of four distinct teams: Policy, Oversight Liaison, ITARS and TRM Review, and Contracts Management.

Functions and Activities

- The policy team Service scans current and burgeoning federal laws, regulations, and guidelines to determine their impact on VA's information security posture. It develops Departmental policy that complies with Federal laws, regulations and guidelines, and it manages the Department's Risk-Based Decision process.
- The oversight liaison provides reporting service for VA's annual and quarterly FISMA reports to OMB and Congress, and serves as a Departmental representative to OMB and DHS via the Max portal and CyberScope.
- The ITARS and TRM review team conducts reviews of more than 6,000 Departmental IT procurements annually to ensure that products and services are compliant with Departmental and Federal policy and guidelines. This team also serves as the OIS representative to the TRM, ensuring that products supported by the TRM possess all the necessary security controls to ensure VA data is protected as necessary.
- The contracts management team serves as the CSPC COR for all CSPC contracts, conducting onboarding services, invoice review and payment, and contract kick-off and closure services.

Certification Program Office

Overview

Certification Program Office (CPO) Service oversees and directs the development and operation of the Department-wide IT system testing and certification assessment and authorization (A&A) program. This office focuses on the certification testing necessary to determine the effectiveness of security controls as specified in National Institute of Standards and Technology (NIST) Special Publications (SP) 800-53,

800-53A, 800-37, and Federal Information Processing Standard (FIPS) 200. Certification results inform Department authorizing officials in making risk-based decisions necessary to place development systems into production and allow production systems to remain in operation. The Office establishes long- and short-range plans for continuously monitoring and managing the Department's cyber security risk by setting policy for the Department's IT system security accreditation program. This team oversees the development of processes and security documentation to support the security assessment and authorization of all VA IT systems. This documentation includes but is not limited to privacy impact assessments, risk assessments, system security plans, configuration management plans and contingency plans.

Functions and Activities

- The CPO team provides certification recommendations in accordance with 6500 and NIST guidance for all operational systems going through the Assessment and Authorization (A&A) process. The reviews include analysis of NIST control compliance, POAM, vulnerability scans, code reviews, as well as security documentation reviews. The team publishes standardized SOPs, provides training, as well as support to the executive staff in the Authorization to Operate (ATO) chain.
- The CPO team manages the Governance, Risk, and Compliance (GRC) tool RiskVision, that directly supports the A&A process. The team manages the programs, workflows, connectors, reporting, training, and all other aspects of the tool for a successful A&A program. The team also provides reporting to SROM in areas including OMB, FISMA, and P.L. 109-461. The team provides support to the end user community at large including OIS staff, SDE and program office staff, as well as executives and oversight stakeholders.
- The CPO team manages the OMB FISMA system inventory in accordance with policy, NIST guidance, and the direction of the chartered RiskVision Working Group (RVWG). The team also reconciles the FISMA inventory against the VASI inventory in concert with VA Enterprise Architecture.
- The CPO team supports the PCI card issuing station assessments and case management through an agreement MOU with the HSPD12 program office.

Security Architecture and Software Assurance

Overview

Security Architecture and Software Assurance oversees the identification, prevention, and remediation of IT security deficiencies. It ensures that VA technical security initiatives are integrated throughout VA organizations and IT infrastructure. The Software Assurance (SASA) directorate's mission is to support the application of a comprehensive cyber security program, capability and strategy to describe, assess and continuously monitor the VA environment. This assists in the application of an all-inclusive and rigorous method for describing and monitoring the current and future structure(s) and behavior(s) of the cyber environment. These actions provide an in-depth understanding across all levels of the cyber posture to support alignment with the organization's core goals and strategic direction. SASA is made up of four distinct technical security teams; Software Assurance, (SwA), Enterprise Visibility and Vulnerability Management and Platform Analytics, (EVVM), Cyber Security Analytics , (CSA), and Federal Identity Credential and Access Management , (FICAM) Compliance.

Functions and Activities

- The SwA team focus areas is the institutionalization of repeatable, enterprise-wide processes, to ensure security is applied throughout the Software Development Life Cycle (SDLC) for all custom software applications. In the shortest time possible, these processes and the skills of VA's internal and contract developers need to reach a level of maturity such that all software development teams can "build security in" with little or no assistance from the central software assurance organization, which then switches from the startup/investment/growth phase to steady-state as software assurance reaches maturity within VA.
- The EVVM concentration encompasses endpoint visibility including desktops, laptops, servers, and network capable devices. It is geared towards gaining visibility into the inventory data, device configurations, and security compliance information on all endpoints throughout the VA which is critical to cyber security analysis. Extensive near real-time reporting and cyber security analysis is necessary to generate executive dashboard summaries, reporting artifacts, and reporting requests to meet customer demand .
- The CSA takes a deep dive into the configuration of the systems to understand how they share data and enforce security. Then team analyzes individual devices, components and systems at various levels of the Open Systems Interconnection (OSI) model to develop comprehensive assessments of the security posture and then makes recommendations for improvement, that are aligned with the overall cyber security strategy of the VA.
- The FICAM Compliance office has two broad tasks. First, to ensure VA's FICAM services are in compliance with FISMA requirements, and second, that those FICAM services are being used throughout VA in fulfilling cybersecurity controls. The Compliance office ensures all aspects of information security are followed and implemented for FICAM programs in VA. The office validates process, system, and procedural compliance of FICAM systems and programs with Federal and VA information security policies and standards, as well as ensuring VA systems and applications are using those systems as part of their overall information security compliance. The office consolidates VA's expertise on FICAM systems in the areas of system security and compliance and risk management as it relates to the implementation and use of those systems.

Emergency Response Team

Overview

Emergency Response Team deploys to sites within VA with approved management tasking by VA senior leadership to perform computer forensics on VA's IT assets or to perform external threat assessments, which consist of vulnerability scanning and penetration testing as a means to improve the enterprise security posture and to provide assistance in the event of a compromise. It proactively evaluates overall security program effectiveness at specific sites and provides technical advice needed to remediate deficiencies.

Functions and Activities

- Perform computer forensics on VA's IT assets or perform external threat assessments (e.g., vulnerability scanning and penetration testing).
- Evaluate overall security program effectiveness at specific sites.

- Provide technical advice needed to remediate deficiencies.

Federal Identity, Credential and Access Management Compliance

Overview

The FICAM Compliance office has two broad tasks. First, to ensure VA's FICAM services are in compliance with FISMA requirements, and second, that those FICAM services are being used throughout VA in fulfilling cybersecurity controls. The Compliance office ensures all aspects of information security are followed and implemented for FICAM programs in VA. The office validates process, system, and procedural compliance of FICAM systems and programs with Federal and VA information security policies and standards, as well as ensuring VA systems and applications are using those systems as part of their overall information security compliance. The office consolidates VA's expertise on FICAM systems in the areas of system security and compliance and risk management as it relates to the implementation and use of those systems.

Functions and Activities

- Conduct Security Oversight of FICAM Services.
- Review System Security Plans for FICAM Service components.
- Review Risk Assessments for FICAM Service components.
- Review Risk Based Decisions relating to implementation of FICAM Services.
- Provide FICAM SME support to FSS ISOs during their reviews, assessment, and monitoring of FICAM Service Components.
- Review business requirements of FICAM Service components for cybersecurity compliance.
- Ensure Security Use of FICAM Services:
 - Participate in PMAS Milestone Reviews to review compliance with the use of FICAM Services as called for by the VA Enterprise Architecture (EA) Enterprise Technical Architecture (ETA) Compliance Criteria and related Federal and VA policies
- Review all System Security Plans for use of FICAM Services.
- Review Risk Based Decisions where an application or service seeks to not use FICAM Services.
- Provide FICAM SME support to FSS ISOs when requested during their reviews, assessment, and monitoring of VA services and applications.
- Provide FICAM security SME support to OI&T for the development and improvement of Enterprise Architecture, Security Planning, Strategic Plans, and related VA directives, policies, and standards.

- Represent VA cyber security interests in federal security forums such as NIST, and the CIO Council Information Security & Identity Management Committee (ISIMC) and its standing subcommittees.

VA Network Security Operations Center

Overview

The VA Network and Security Operations Center (NSOC), defends, manages, and monitors the network operating status and cyber security posture of the Department by providing the day to day management, operation and configuration of the enterprise network infrastructure, internet gateways, the delivery of enterprise security systems and services, the monitoring and reporting of security incidents, the conduct of threat and vulnerability analysis, the validation of adequate security controls within the enterprise and the full range of functions across the spectrum of activities relating to incident management, incident response and enterprise network management.

The NSOC is responsible for protecting VA information on a 24 x 7 basis. In doing so, the NSOC monitors, responds to and reports cyber threats and vulnerabilities. The NSOC is responsible for the security posture of the Internet Gateways with the authority to direct isolation of VA IT resources.

The NSOC is also responsible for the design and implementation of all systems placed within the boundaries of its responsibilities to include the four Trusted Internet Connection (TIC) Gateways, two NSOC locations (Hines, IL and Martinsburg, WV). The NSOC will contribute design requirements and specifications that address the security aspect of Enterprise systems.

The NSOC is also the command center for managing and monitoring the health of the Enterprise network to the Wide Area Network (WAN) backbone.

Functions and Activities

- Provides 24/7/365 monitoring and incident response for cybersecurity threats and incidents.
- Provide proactive cyber threat intelligence analysis, threat detection and network forensic analysis to deter, defeat or reduce the impact of threats to the enterprise from emergent and complex attacks or intrusions.
- Investigate and analyze malware, and correlates events to determine cyber threat posture.
- Performs proactive analysis of security tool configurations and capabilities to ensure optimal performance and interoperability of security tools.
- Provide configuration updates, maintenance; management and monitoring of security sensors to ensure protections in place are current and viable.
- Monitors and manages the Trusted Internet Connection (TIC) Gateways and the WAN backbone.
- Conducts vulnerability and penetration testing of the VA enterprise network, TIC gateways, and programs hosted in the cloud.
- Provides assessments for Web applications, source code analysis, and mobile security testing.

Authorities

E-Government Act of 2002

Federal Information Security Amendments Act of 2013 (H.R. 1163)

OMB Circular A-130, Appendix III

OMB M-00-13

OMB M-03-22

OMB M-06-16

OMB M-07-16

OMB M-01-15

Federal Information Security Management Act (FISMA) of 2002

Health Insurance Portability and Accountability Act (HIPAA) Standards

Federal Regulations/Federal Information Processing Standards (FIPS)

GAO 09-232G – Federal Information System Controls Audit Manual (FISCAM)

National Institute of Standards & Technology (NIST) Special Publications

NIST SP 800-53 Revision 4

Cybersecurity Act

Cybersecurity Executive Order 13587 of February 2013

Executive Order 13321: Critical Infrastructure Protection in the Information Age

VA Directive 6500

VA Directive 6501

VA Directive 6502

VA Handbook 6500

Department of Homeland Security (DHS) Trusted Internet Connection

Homeland Security Presidential Directive 7 (HSPD)

Homeland Security Presidential Directive 12 (HSPD)

IG FISMA Audit 2011

The Veterans Benefits, Healthcare, and Information Technology Act of 2006 (P.L. 109-461)

Enterprise Program Management Office**Overview**

The Enterprise Program Management Office (EPMO) is VA's IT enterprise structure for conducting major initiatives, monitoring key information and improving project execution to deliver better outcomes to VA business partners and Veterans. EPMO provides a consolidated enterprise wide approach to identify, select, prioritize and successfully execute technology portfolio of projects. EPMO is responsible for the execution of all program/project management and software development.

Functions and Activities

- Align portfolios to objectives.
- Enhance visibility and governance.
- Analyze and report portfolio performance metrics.
- Ensure overall portfolio health.
- Optimize resources for projects, people and timelines.

Lean Systems Engineering

Overview

Lean Systems Engineering oversees all of the portfolios and Application Management, the Optimization and Visualization work in tandem with the EPMD to ensure each portfolio has the resources and capabilities necessary to successfully execute it, and also provides oversight functions for program and project management. Strong emphasis on incorporating identification methods that focuses on continuously meeting stakeholders need. Lean Systems Engineering works with Acquisition Support, Application Management and portfolio offices to classify efforts which will impact how each investment moves through the remainder of execution.

Functions and Activities

- Dashboard/Visualization (metrics gathering and analysis).
- Development process Tools.
- Contracting/Acquisitions Administration.
- Budget Execution/Human Resources.
- Training.

VIP, Dashboard and Visualization

Overview

OI&T's managerial process for its portfolios, programs, and projects, VIP enables VA to deliver usable and useful products that are centered on the needs of users through more frequent releases.

Functions and Activities

- Focused on value over artifacts.
- Only two critical decision points.
- Product team stays engaged for 90 days following release.

Acquisition Support

Overview

The Acquisition team provides skilled acquisition and contract subject matter experts (SMEs) to support each portfolio, program, project and office within EPMD with their contracting needs. Acts as the liaisons between the Program/Project Managers and the Acquisition Center and has two primary areas: Acquisition Execution and Business Operations. Business Operations is responsible for quality and management of all EPMD acquisition information, metrics and execution reporting, acquisition analysis and active contract collection and tracking. Acquisition Execution is responsible for acquisition planning and on time execution of the annual budget through contract obligation.

Functions and Activities

- Brings expertise in contractual methodologies for development, sustainment and enterprise level acquisitions.
- Performs upfront Acquisition and Budget planning to assist OIT in meeting project goals and on time execution.
- Works with PMs and teams to translate program requirements into contractual requirements.
- Determines acquisition strategies and approaches to achieve optimal solutions from cost, performance and schedule.
- Takes the lead in developing and processing acquisition packages.
- Performs quality metrics and execution reporting analysis.

Budget Execution and Planning Office

Overview

Provides current year budget execution and upcoming year budget planning for all major transformational initiatives (MTIs) and a variety of non-MTI projects and activities Budget Leads and Budget Analysts are assigned to each of the MTIs and non-MTI programs and offer high-quality, proactive, and comprehensive budget execution support to assist in meeting VA's strategic goals. Works with Program/Project Managers (P/PMs) to create the program budget operating plan in the Budget Tracking Tool (BTT), provide extracts from the BTT to interested parties as needed, assist with all budget realignment and unfunded/underfunded requests, provide budget data for internal and external program budget briefings, and participate in program Integrated Project Teams to the extent possible. Ensures consistent and accurate messaging on the status of program and project budget execution to all internal and external stakeholders.

Functions and Activities

- Provides upcoming year budget planning and current year budget execution support for all projects and activities in EMPO.

Tools

Overview

When federal agencies develop, procure, maintain, or use electronic information and technology (EI&T), Section 508 requires that federal employees with disabilities have access to and use of information and data comparable to access and use by federal employees who are without disabilities, unless an undue burden would be imposed on the agency. Section 508 also requires that individuals with disabilities, who are members of the public seeking information or services from a federal agency, have access to and use of information and data that is comparable to that provided to the public who are not individuals with disabilities, unless an undue burden would be imposed on the agency.

Functions and Activities

- Oversight of Section 508 with VA infrastructure.

- Develop and implement VA agency wide Section 508 Program.
- Develop/update of Section 508 policy and handbook.
- Educate VA employees on Section 508 policy and procedures.
- Provide progress assessments and ad hoc reports to senior officials in office of the Chief Information Officer (CIO).
- Provide expert technical advice and guidance on Section 508.
- Assess, monitor, and report on Section 508 conformance.
- Establish testing protocol which supports assessment, testing and reporting of Section 508 violations and processes for remediation.
- Recommend Section 508 compliant software for testing of agency documents and websites.
- Provide training and technical support to agency employees.
- Ensure necessary Section 508 language is incorporated in all EIT acquisitions.
- Assess proposed E&IT (Electronic & Information Technology) products for Section 508 conformance within VA's Enterprise Architecture Framework, to include: (E-Gov initiatives programs, IT Tracker products, Web based applications, Software applications).
- Provide Section 508 information in response to Department of Justice, OMB, and other Federal Agencies annual surveys.

Program Planning

Overview

Program Planning & Oversight (PP&O) promotes and supports coordinated planning, execution and oversight of EPMD development projects. PP&O's key functions include but are not limited to support in budget formulation, planning (multi-year) and reporting oversight, working within the parameters of the Veteran-focused Integration Process (VIP) and guided by OMB Circular A-130 which implements the Clinger-Cohen Act of 1996. PP&O supports the EPMD through representation to ITRM as a Service Provider and the VIP Business Office as key stakeholders to accomplish these functions. Within the EPMD we work closely and collaborate with EPMD Acquisition & Contract Administration (ACA) and EPMD Budget Planning & Execution counterparts.

Functions and Activities

- PP&O supports the EPMD in a variety of activities that support the reporting and monitoring of project performance and compliance with VIP.
- Oversees submission of Major IT Business Case and Major IT Business Case Details for EPMD Investments and projects to the Federal IT Dashboard, as required by Office of Management and Budget (OMB) fiscal year Guidance and OI&T requirements.

- Supports “Certification of Funds” of IT Appropriation Development, Modernization & Enhancement (DME) projects for EPMO as required by Consolidated and Further Continuing Appropriations (Public Law). Initial letter is issued on a fiscal year basis and updated quarterly thereafter.
- Coordinates Multi-Year Programming (MYP) within EPMO which covers budget formulation through pass back and 5 years of out-year planning as required by ITRM.
- Creation and Maintenance of the EPMO Enterprise Project Structure (EPS). The EPS provides a standard naming and numbering structure for all projects, provides a framework for organizational alignment and rollup, and correlates execution year funding with OMB reporting and Budget Tracking Tool (BTT) entries. The EPS is updated daily and published quarterly.
- Maintain contract support for Function Point Analysis and estimation information within the EPMO.
- Provides administrative and support for the EPMO Project Repository (TSPR) that serves as the document repository for all EPMO VIP projects so information is made available and can be viewed by our Business Partners.

Transition Release and Support

Overview

Works in tandem with Project Management and Execution to prepare for transition and releases and handles the transition and release of completed projects. The office will collaborate with Release Agents to develop and deliver quality products by overseeing the new single release process within the VIP frameworks. Will work with project teams to develop release plans encompassing the broad set of release goals, preliminary deployment information and critical details including information on user on-boarding and/or transition, data migration, contingencies specific to the release, final customer validation/verification, and the post-deployment monitoring approach. Also responsible for overseeing the new unified release calendaring functions using POLARIS which was developed by through SharePoint to support the VIP framework.

Functions and Activities

- Transitions product sustainment to Service Delivery & Engineering for O&M operations,.
- Manages Integrated Calendar (POLARIS) across OI&T.
- Overseen by DAS, EPMO as an aspect of check and balances.

Product Support-Health

Overview

Health Products manages the projects for the development of those IT products that address the needs of Veterans and health care providers through the management of health care information. These IT solutions provide leading edge information technology solutions to support health care delivery.

Functions and Activities

- Collaborate with business owners to identify information technology needs.
- Partner with business owners to create an OI&T strategic roadmap.
- Capture the capabilities and requirements for product builds.
- Identify Key Performance Indicators (KPIs) to ensure products align with VA goals and priorities.

Product Support-Benefits

Overview

Benefits Products manages the project for the development of those IT products that facilitate the effective delivery of Veteran benefits through advanced technology solutions. Operates as OI&T cornerstone for Non-Major Initiative projects and serves as the source of necessary interfaces between Major and Supporting Initiative development.

Functions and Activities

- Provides diagnosis and correction of program errors after software release.
- Provides modification of software to interface with a changing environment or congressional mandates.
- Provides modification of software to improve future maintainability or reliability as a result of a requirement to perform hardware re-platform or operation system/system software upgrade.
- Resolves trouble tickets to ensure day-to-day continuity of benefit payments and services, user interface screens, reports, letters, data interfaces, etc.
- Performs enhancement work as required by the Business Lines for those products with no corresponding development team.

Product Support-Corporate

Overview

Corporate Products manages the projects for the development of those IT products that address the use of VA corporate and management information. Through the provisioning of leading edge information technology solutions and services, Corporate supports, enhances and improves the VA operations.

Functions and Activities

- Resolves trouble tickets to ensure day-to-day continuity of Insurance Payment Systems services, user interface screens, reports, letters, data interfaces, etc.
- Insurance support team provides minor enhancement and bug fix support to the Insurance business line.
- Responsible for recording, analyzing, resolving and closing trouble tickets.

- Perform routine application maintenance and defect repair.
- Responsible for oversight of corporate sustainment contracts.
- Responsible for Mandatory Sustainment budget oversight.

Product Support-Enterprise Application

Overview

Product Support-Enterprise (PS-E) provides, operational support, administration, 24 x 7 monitoring, and of all enterprise scoped health, benefits, cemetery, corporate management, administrative and financial production systems. This includes applications, databases, websites and middleware. Product Support-Enterprise works closely with DCO and EIS to ensure stability and availability are always inline. Product Support-Enterprise provides support to enterprise applications in all VA Facilities. PS-E will continuously monitor applications performance, apply patches and fixes to keep applications current, update applications for new capabilities, maintenance, integration, performance optimization and document changes for stability. PS-E plays a critical role in ensuring that the VA business processes functions are reliable and correct.

Functions and Activities

- Application down - This happens when the online or batch process has abended (crashed), causing the application to stop. These problems are typically classified at the highest severity level and must be addressed immediately.
- Substantial logic error - Sometimes problems occur in an application that can produce disastrous results, even though the application is not down. In some respects, these errors are worse than having the application down. When an application is down, you know what you are facing. When a substantial logic problem occurs, but the application is still up, the outcomes produced may be erroneous, and bad decisions can occur. Once these errors are found, it can also be difficult to clean up the errors already produced and get the application reliable again.
- Fixing errors - fixing errors is similar to the "responding to production emergencies", however the severity level is not as great. This category includes the "normal" bugs and errors that pop up from time to time. For instance, a nightly batch job that goes down may just need to be resubmitted. Another example is an error that occurs on an online screen that may not occur the next time it runs. Or a report may print asterisks in a field that is not large enough to hold the entire value. All of these are examples of fixing errors that do not rise to the level of a production emergency.
- Responding to environment changes - Sometimes events take place that require changes to an application, or testing, that do not originate in the support group.
- Software/hardware upgrades and changes - this category of service deals with trivial software/hardware upgrades and changes that is similar to environment changes. This category covers services involved with internal staff initiated changes.

- Assisting with business processes - Business processes that take place on a regularly scheduled basis. Normal and ongoing assistance with these business processes is part of the service provided by the support staff.
- Documentation updates - Compiling documentation updates includes the time associated with updating system, user, or support documentation. This represents the time associated with minor documentation updates.

Calendar

Overview

Functions and Activities

- Partner-specific, unified calendar.
- Continually updated.
- Full visibility into upcoming releases.

Release Management

Overview

Release Management has overall responsibility for the transition of certified products that will be released to the field and lifecycle management of those products through retirement. Release Readiness: Protects the production environment and its services through the use of formal procedures and checks that govern the scheduling and deployment of changes. Change and Configuration Management: Establishes and manages enterprise change and configuration management processes for production deployments. Release Management verifies the configuration health of deployments, consistent with OI&T strategies and standards.

Functions and Activities

- Ensures that the Project Team has the complete list of product data deliverables.
- Provides feedback throughout the build/development phase to the Project Manager, the Configuration Manager, and the Testing Manager.
- Collects certain metrics at the end of each Sprint.
- Provides the status of the product data to the three decision-makers: the Portfolio Manager, the Product Owner, and the Receiving Organization, at the end of build/development phase in preparation for CD2 decision.
- Evaluates release metrics after full production installation.

Enterprise Project Management

Overview

Responsible for overseeing and directing each of the four IT portfolios, all seeking to improve performance and deliver appropriate IT strategy within the organization. Oversees program and project managers in enterprise-wide scheduling, resource allocation, testing, design, engineering, and implementation, and works closely with the account managers to ensure that they have the information they need for their work with our business partners.

Functions and Activities

- Consolidates programs and projects under four VA business line portfolios. (Health, Benefits,/Cemeteries, Corporate, and Enterprise services).
- Portfolios directly support VA strategic objectives.
- Direct tracking of budget funding from portfolio down to project level.
- Integrates security into all aspects of project.

Application Management

Overview

Provides competency-based developer, data management, and technical analysis resources to the projects that build the applications Veterans use to manage their health care and secure their benefits, along with those applications that VA uses to support Veterans. Employees support phases of the software development lifecycle as implemented in EPMO under the guidelines. Application Management develops and maintains tools, conventions, and work product standards for consistency and efficiency across projects and competencies.

Functions and Activities

- Perform the planning and execution of functional testing, regression testing and system integration testing.
- Ensures new or changed software code satisfies documented technical requirements.
- Ensures code changes have not introduced defects that affect other parts of the application.
- Ensures the products will operate in a production environment while correctly exchanging data with other products.
- Performs pre-deployment software quality assurance checks.

Health

Overview

VA uses information technology to enable the Department to provide access to care and services that out nations Veterans have earned and deserve. The primary focus of VA Health Initiatives is on

development and execution of quality IT projects that address that needs of Veterans and health care providers through the management of health care information, along with sustainment of production software that keeps the mission going.

Functions and Activities

- Product Support.
- Serve as experts on deployed software.
- Retire/consolidate products to reduce cost and/or exploit new benefits.
- Develop and deploy new mission critical systems.
- Access to Care – VistA Surgery.
- Caregiver’s legislation (enhancements).
- EDI Transactions – Payer & Provider.
- VHA Research - Genomic Information System for Integrative Service (GenISIS); Research Administrative Management System (RAMS) Integration.
- Health Administrative Systems - Patient Statement Enhancements; Revenue Reporting Enhancements; Prosthetics Purchasing and CPRS Enhancements; Claims Processing and Eligibility Enhancements; Purchased Care Program Integrity Enhancements; Voluntary Service System (VSS) Enhancements; Revenue Reporting Enhancements.
- Health Provider Systems – Computerized Patient Records System (CPRS) Enhancements.
- Healthcare Efficiency - Non VA Care Enhancements; Beneficiary Travel Self-Service System.

Benefits, Appeals and Cemeteries

Overview

Benefits, Appeals, and Memorials (BAM) is responsible for utilizing advanced technology solutions and development projects to ensure Veterans’ benefits are delivered on time and without complication. BAM also supports legacy applications for benefits products. Projects included in this area support VA’s goal of eliminating the backlog of Veterans’ claims. They also aim to enhance Veterans’ access to comprehensive VA services and benefits especially in the delivery of compensation and pension claims processing. The Memorials portfolio promotes improvement in the efficiency of Memorial products to support NCA in achieving its goals to honor Veterans and their families with final resting places in national shrines and with lasting tributes that commemorate their service and sacrifice to our nation.

Functions and Activities

- Veterans Benefits Management Systems (VBMS) assists in eliminating the existing claims backlog and serves as the enabling technology for quicker, more accurate, and integrated claims processing in the future.

- Benefits Education aims to fully-automate VA education claims processing and migrate all VA educational programs onto an integrated, sustainable platform.
- Benefits Integration is designed to improve the speed, accuracy, and efficiency in which information is exchanged between Veterans and the VA.
- Memorials is responsible for developing and maintaining Memorial Benefits Management and Cemetery Management including providing more standardization and automation for NCA cemeteries to generate internment notices/dig slips and track remains. The Memorial Benefits Management System (MBMS) provides interoperability with external systems, allowing Veterans, their next of kin, and other users to save time with faster eligibility and forms processing capabilities and benefit delivery workflows, provide navigation to cemetery and gravesite, Veteran, Next of Kin and funeral director self-service.

Corporate

Overview

Corporate Portfolio manages the IT development projects for IT systems that support VA corporate administration business units such as Human Resources Administration, Office of General Council, OSDDBU and Office of Acquisition, Logistics and Construction and Office of Management. Corporate IT systems support the delivery of services to VA employees and Veterans by enabling greater efficiencies and processes to produce relevant internal, foundational information and a more effective VA workforce.

Functions and Activities

- Interfaces with VA customer business units and IT Customer Account Managers to develop enterprise IT strategies, solutions and IT roadmaps.
- Formulates strategy and provides technical direction, guidance, and policy compliance to ensure that IT resources are managed for the VA in a manner that adheres to various federal laws and regulations.
- Manages enterprise application development and sustainment activities.
- Development consists of planning, developing (or acquiring), and testing applications that meet business requirements.
- Provides available, adaptable, secure, and cost effective information technology products and services to VA customers, enabling VA staff to provide mission-critical support to the Nation's Veterans.
- Focuses on the modernization of resources management, legal, training, and information management systems.

Enterprise Services

Overview

Enterprise Services is responsible for optimizing resources and services to our Veterans and VA. It identifies leverages, deploys, and maintains reusable shared services on underlying common technologies and supporting processes. ESS identity and security services provide an enterprise-level approach to managing identity data for Veterans, internal and external users, and their electronic access to VA systems and services. Interagency services provide VA and Department of Defense (DoD) clinicians, care coordinators, benefits administrators and other staff Veteran health, benefits and administrative data. ESS orchestration services provide and orchestrate service oriented architecture (SOA) services for delivery of a unified Veteran military history, contact information, demographic, benefit and eligibility view to consuming projects and systems. Benefit services deliver unified VBA data and business logic via enterprise services to major initiatives and projects. ESS health services and repositories manage administrative, demographic, and eligibility information as a shared corporate asset, and integrate identity and administrative personal data with associated clinical data across the VHA and external healthcare systems.

Functions and Activities

- Plan, develop, and maintain reusable, shared services for all VA lines of business using standardized technologies.
- Develop and execute a VA-aligned shared services strategy with goals to.
- Increase technology Return on Investment (ROI).
- Enhance communications and provide collaboration tools for the adoption and reuse of shared services .
- Improve the long-term sustainability of solutions.
- Implement performance measurement management to monitor ESS strategy value and outcomes.
- Co-Chair the ESS Center of Excellence (CoE) governance body and lead Service Oriented Architecture (SOA) working groups.

Intake and Analysis of Alternatives

Overview

Intake and Analysis serves as the first stop for business owners seeking guidance in terms of the planning of initiatives involving an IT component. This EPMO component is responsible for working with business owners to develop initial plans that will help in developing credible cost estimates for the VA multi-year planning effort and for proposing an initial solution architecture that takes advantage of shared services of VA's technical infrastructure to increase VA operating efficiency.

Functions and Activities

- EPMO Intake and Analysis has primary responsibility over specific initiatives involving IT after they have been identified by the business component. Further, Product Managers have a secondary role for their products throughout the product lifecycle.
- Serve as IT Product Owners and have life-cycle responsibilities for all products under their portfolios. Their responsibilities extend to work with business owners to capture requirements for product builds and to drive the creation and approval of Product Solution Architectures.
- Intake and Analysis serves as OI&T's entry point for technical support for specific initiatives prior to the funding of these initiatives.
- Responsible for transitioning products.
- Develops cost estimates, budgets, coordinates communications and responds to Congressional and GAO activities, evaluates and improves Intake and Analysis processes, and provides human resources and administrative support to other elements of the office.

Corporate Products and Activity Management

Overview

Corporate and Activity Management Products supports VA's corporate and activity management customers by analyzing their needs, objectives and strategic plans through the advocacy of enterprise-wide solutions and creation of product strategies and roadmaps. Corporate supports those staff organizations and offices that report directly to the Immediate Office of the Secretary. Activity Management supports VHA patient scheduling, movement, transportation and supply management products.

Functions and Activities

- Collaborate with business owners to identify information technology needs.
- Partner with business owners to create an OI&T strategic roadmap.
- Capture the capabilities and requirements for product builds.
- Identify Key Performance Indicators (KPIs) to ensure products align with VA goals and priorities.

Enterprise and Corporate Products

Overview

Serves as principal advisor to VA leadership on interoperability matters and serves as a liaison to the VA/DoD IPO and DoD's Defense Medical Information Exchange (DMIX) Program Office on all interagency interoperability matters. Interoperability and Enterprise Shared Services (IESS) reviews, analyzes, and evaluates VA's interoperability and shared services plans, products and services, working with PACE to plan and inform the allocation of resources, including the development of an annual BOP and all Multi-Year Planning (MYP) budgets for all aspects of Electronic Health Record Interoperability (EHRi), in alignment with SECVA and CIO's priorities and in compliance with Congressionally mandated

requirements. IESS collaborates with stakeholders within DOD, IPO, VHA, OIT and other Federal and private HIE partners to identify and align clinical, technical, interagency and Congressional requirements for interoperability. IESS leads the planning, budgeting, implementation coordination, testing and compliance of all VA HIE Interoperability infrastructures within the VA's portfolio of IT products.

Functions and Activities

- Work with product engineers to drive the creation and approval of product solution architectures.
- Work with product estimators to develop initial cost estimates for IT.
- Capture planning decisions in Product Planning Documents (PPDs).
- Coordinate with business owners to ensure their needs are added to IT Multi-Year Planning (MYP) and Budget Tracking Tool (BTT).

Clinical Products

Overview

Functions and Activities

Interoperability and Enterprise Shared Services

Overview

Functions and Activities

Product Analysis and Cost Evaluation

Overview

Product Analysis and Cost Evaluation enables and supports product life-cycle cost estimation, and internal ASD PPM product lines in correspondence management, human resource support, and budget development and execution support.

Functions and Activities

- Coordinate, develop and implement annual updates to the Product Planning Documents (PPDs)/Business Case Documents (BCDs) templates.
- Maintain and enhance the Intake Process of business owner needs through completion of the PPD/BCD and investment requests in OIT's Multi-Year Programming (MYP) activities.
- Maintain and update the PPD/BCD tracker, PPM PPD/BCD Overview, and ASD/PPM 101 presentation.

- Provide cost estimation support for PPDs/BCDs, VistA Evolution (VE) Life Cycle Cost Estimate (LCCE), and VE Cost Benefit Analysis (CBA).
- Secure release of VE development, modernization and enhancement (DME) encumbered funds from the House Appropriations Committee (HAC) and Senate Appropriations Committee (SAC).
- Develop responses associated with legislative language requirements found within Military Construction, Veterans Affairs, and Related Agencies Appropriations bills, which lift encumbrances of funds for VA's VE program.

Benefits Determination and Delivery Products

Overview

Functions and Activities

Project Planning

Overview

Project Planning is a subset of Project Management pertaining to the creation and monitoring of project schedules. Project schedules are the lifeblood of projects, detailing the progress and health of the project against the projected plan and budget. Monitoring plans against actual progression will give early warnings of project execution issues and missed dates, giving the project team ample time to address and mitigate problems so that planned dates can be met. Planning management creates and maintains a standard activity framework that project plans and schedules should fit within. Management defines the tool (currently Primavera) to be used and trains appropriate personnel on the tool and standardizes tool and methodology use. Planning management defines for senior management support the EPMD strategic goals with respect to enterprise project scheduling tool and defines requirements for metric data to be collected from enterprise project scheduling tool.

Functions and Activities

- Creates and maintains project schedules. Ensures each member of the project team participates in defining and validating her/his own tasks within the project.
- Works with the PM and team to develop/baseline/track performance against/forecast to ensure projects remain within budget and on schedule.
- Administer Primavera Timesheets.
- Update all necessary project repositories with project planning documentation, project planned/actual dates, and other planning metric data as required.
- Assist with creation of project planning documentation and ensuring PMAS documents and processes are completed to the project plan.
- Perform schedule variance analysis and analyze/optimize the schedule as needed.

- Perform project schedule health checks.
- Monitor compliance with PD's Minimum Schedule Requirements.
- Re-plan and reschedule as needed.
- Back-up PM when appropriate for project planning purposes.

Stakeholder Engagement

Overview

The office of Stakeholder Engagement advises the DAS and Executive Directors on complex and sensitive issues that cross organizational boundaries within the Department. The Stakeholder Engagement team is the primary interface between internal and external stakeholders and the EPMO. The primary objective of the office is to ensure consistent, clear messaging to all EPMO stakeholders through proactive, high quality communications products and services. In addition, the office of Stakeholder Engagement provides professional, confidential, and seamless administrative support to EPMO's Senior Leadership.

Functions and Activities

- Manage all EPMO internal and external correspondence processes via Veterans Affairs Internet Quorum (VAIQ) and internal tracking mechanisms.
- Serves as EPMO's point of contact with the OI&T Front Office, OI&T Correspondence Team, and OI&T Communications Team.
- Facilitates EPMO engagement and interface with OMB, GAO, OIG, and Congress on highly sensitive Department matters.
- Analyzes recommendations regarding VA, OI&T, and EPMO policies, directives, and guidelines having Departmental and/or interagency implications and impacts.
- Prepares EPMO congressional correspondence and testimony as needed.
- Manages the internal communications process for EPMO and the DAS including executive messaging, regular EPMO newsletters, and awareness campaigns within EPMO.
- Requests, reviews, and submits EPMO performance data and analysis reporting to other internal and external entities.
- Reviews and approves publishing of content on internal EPMO sites, ensuring content is in compliance with administrative standards.
- Provides professional, confidential, and seamless administrative support to EPMO's Senior Leadership.
- Records, shares, and tracks executive meetings, briefings, and speaking engagements.

Capacity and Performance Engineering

Overview

Capacity and Performance Engineering (CPE) is responsible for evaluation of infrastructure solutions and project deliverables in both development and production contexts ensuring that engineered infrastructure solutions are sufficient to support VA deployed IT systems. CPE leads analysis of newly developed workloads and system solutions, providing mastery-level technical support and oversight for Health, Benefits, and Memorial Corporate and Interagency IT work products. CPE is further responsible for providing a leadership role in capacity analysis of application and infrastructure IT solutions by providing forecasts of capacity and utilization, operational readiness reviews, capacity analysis, and requested engineering technical analysis to inform the inter-service, inter-division, and/or inter-organizational effort it supports. CPE provides ongoing project support inclusive of operational quality audits as part of Operational Readiness Reviews (ORR) which analyzes key product data, including requirements, design, traceability; testing, operations, and capacity/performance in order to determine if IT best practices were followed, if VA compliance standards were adhered to, and if the product has met the criteria for release. Additionally CPE Capacity Evaluations provide estimates of the potential impact of new or enhanced OI&T products on VA enterprise computer system capacity and resources in support of planning and service delivery actions. For all infrastructure and system testing activities CPE employs capacity modeling and evaluation techniques to evaluate architectures and applications prior to, during, and after deployment. All of CPE work is supported by infrastructure services which provide means to provision system development environments and house all data required for capacity and informatics work products.

Functions and Activities

- Data Center Capacity Planning and Analysis.
- Operational Readiness Review.
- Architecture Validation and Technical Analysis.
- Root Cause Performance Analysis.
- Capacity Planning and Forecasting.

Project Special Forces

Overview

The EP MO is VA's IT enterprise structure for conducting major initiatives, monitoring key information and improving project execution to deliver better outcomes to VA business partners and Veterans. As the various EP MO divisions handle critical lean system engineering, project management, intake and analysis of alternatives, and transition, release, and support, the project special forces team is the triage unit within EP MO to ensure teams can successfully deliver key IT functionality to our business customers.

Functions and Activities

- Assist projects when they are experiencing challenges with delivering.
- Mentors project teams on opportunities for improvement.

- Advise and guide portfolios within the project management directorate.
- Tracks and trends challenges across the EPMO portfolio and identifies systematic and isolate incidents that provide opportunities for improvement.

PM (PROMOTE PM Fellows)

Overview

The Project Management PROMOTE PM Program is a selective professional development initiative for aspiring mission critical project managers. This 14 to 15-month cohort program accelerates development of future PM leaders, developing them through a unique experiential learning model to possess the mix of skills necessary to effectively manage mid-sized projects. Together, the Veterans Affairs Acquisition Academy (VAAA) and its customers share the mission of developing a pipeline of future leaders who possess the required mix of skills necessary to be lasting PM change agents within their organization. The program accelerates time to competency for new hires or staff transitioning to mid-level project management roles. Each PROMOTE candidate progresses through the required FAC-P/PM curriculum and reinforces the technical and leadership competencies with virtual learning activities, skill building workshops, and job rotations to create a holistic learning experience.

Functions and Activities

- Under close supervision, PROMOTE PMs work through the VAAA curricula designed for the program.
- Works with supervisor one on one to ask questions and obtain guidance about the functional application of concepts taught during training.
- Completes additional virtual training opportunities as assigned by supervisor between rotations at the Academy.

Authorities

Information Technology Management Reform Act of 1996 Title 40
 Clinger-Cohen Act of 1996
 P.L. 104-106
 Veterans Identity and Credit Security Act of 2006 (HR 5835)
 E-Government Act of 2002
 Federal Information Security Management Act 2002 (FISMA)
 The Federal Records Act of 1950 (44 US §3101)
 The Freedom of Information Act, as amended 5 U.S.C. 522
 The Government Paperwork Elimination Act of 1998
 Government Performance Results Act (GPRA) of 1993
 Government Management Reform Act (GMRA) of 1994
 P.L. 109-114, Military Quality of Life and Veterans Affairs Appropriations Act of 2006
 OMB Circular A-11, Part 7
 OMB Circular A-130
 OMB Circular A-130 Revised
 OMB Circular A-11 Part 7 Section 300
 OMB Circular A-11, Section 5

OMB Memorandum, The Federal Acquisition Certification for Program and Project Managers
 OMB Memorandum, Revisions to the Federal Acquisition Certification for Program and Project Managers
 Office of Federal Procurement Policy (OFPP) Developing and Managing the Acquisition Workforce
 Services Acquisition Reform Act of 2003
 VA Acquisition Academy Program Management
 U.S.C. 44 § 3506
 Rehabilitation Act of 1973
 Veteran Benefits Improvement Act of 2008 Privacy Act of 1974
 Health Insurance Portability and Accountability Act
 VA Directive 4900
 P.L. 109-461 Title IX

Office of Service Delivery and Engineering

Overview

The Office of Service Delivery and Engineering (SDE) direct all operational and maintenance activities associated with VA's IT environment on behalf of the AS/IT. SDE oversees and manages the VA data centers, the IT network and telecommunications; monitors and manages production for all information systems and production services; delivers operations services (including deployment, maintenance, monitoring and support) to all VA locations, and conducts all private branch exchange management and maintenance. SDE comprises more than 5,500 IT professionals and administrative/support staff spread across five major components: Field Operations, Enterprise Operations, Enterprise Systems Engineering, National Service Desk and IT Service Management.

Field Operations

Overview

Field Operations directs all operations and maintenance activities associated with the field-based VA IT infrastructure, including overseeing security, operational policy and the execution of the *VA Continuity of Operations Plan (COOP)*.

Regional Operations

Regional Operations coordinates and manages the day-to-day IT operations and IT services across VA field installations. Field Operations supports the IT operational infrastructure, local computing environments and site-level data processing and management capabilities for all VA. Field Operations also ensures successful release and deployment of enterprise products to the field and actively promotes best practices adoption. Field Operations also serves as the customer relationship manager for implementation and integration of customer acquired technology investments, serving to analyze, assess, integrate and deploy technology that has Information Technology dependencies. Field Operations provides desktop support to VA users across the nation.

Technology Management Office (TMO)

Overview

Technology Management Office provides oversight and facilitates field operations technology and process standardization in support of enterprise implementations. provides technical and logistics expertise within SDE Field Operations.

Business Intelligence Office (BIO)

Overview

Business Intelligence Office directs the consolidation and standardization of information collection, database structures, and maintenance of central data warehouses. The BIO also maintains a focus on the front-end business requirements reporting and back-end authoritative data marts.

VACO Support Services

Overview

VACO Support Service provides technical and operational IT support to the VACO campus.

Enterprise Operations

Overview

Enterprise Operations manages all VA enterprise solutions. This office directs all operations and maintenance activities associated with the Enterprise VA IT infrastructure, which encompasses all inherently corporate, missions critical and other IT systems for which a high degree of standardization in operation and management is required. SDE/EO is comprised of four Directorates:

Data Center Operations (DCO)

Overview

DCO is a metrics-driven organization responsible for maintaining a highly available, scalable, and redundant data center infrastructure that will substantially reduce the VA's risk and enable future IT service delivery growth. DCO is responsible for day-to-day operations and management of all VA Data Centers. DCO serves as the broker for external Government and Commercial Data Center Services to meet VA requirements.

Enterprise Infrastructure Support (EIS)

Overview

EIS is responsible for the implementation and operational support of enterprise infrastructure which hosts all enterprise applications. This includes but is not limited to Internal and External Cloud Solutions, Physical and Virtual Server Farms, Mainframes, Enterprise Storage and Backup Systems. EIS manages all enterprise infrastructure systems to the Operating System Layer. This capability includes 24x7x365 on-call support for all Platforms on which Enterprise Solutions reside. EIS works closely with DCO and EAS to ensure stability and availability are always inline. EIS provides Tier 2, Tier 3, and Tier 4

support for Enterprise production systems in all VA Facilities; utilities for system management; and infrastructure monitoring and performance analysis and troubleshooting, including system optimization recommendations for all enterprise systems.

Enterprise Application Support (EAS)

Overview

EAS provides, operational support, administration, and 24 x 7 monitoring, of all enterprise scoped clinical, benefits, management, administrative and financial production systems, applications, databases, Web and middleware. EAS works closely with DCO and EIS to ensure stability and availability of supported application. EAS provides Tier2, Tier 3, and Tier 4 support to enterprise applications in all VA facilities; utilities for applications management, and application optimization recommendations for enterprise applications.

Enterprise Telecommunications Management (ETM)

Overview

ETM formulates strategy, designs architecture, and oversees delivery of national telecommunications services (voice, video, and data transport). ETM assures that highly available telecommunications services are delivered with appropriate privacy and security controls. ETM conducts network capacity planning analyses and network augmentations to assure sufficient bandwidth to support VA business applications. ETM continually integrates new technologies for enhanced telecommunications services.

Enterprise Systems Engineering

Overview

Enterprise Systems Engineering (ESE) provides central systems engineering services and management of a technical framework promoting one technology vision across VA, which supports system optimization, integration and interoperability throughout the enterprise. Systems engineering is an interdisciplinary approach and means to enable the realization of successful systems, proceeding from concept to production to operation.

Functions and Activities

- ESE provides Tier 3 and 4 engineering services to VA IT systems, applying a consistent architecture and planning the systems development life cycle (SDLC), and managing engineering aspects of a project from start to finish. ESE plays lynchpin roles in every stage of the system life cycle.
- Responsibility for conceptual design.
- Integration of standard components into a system solution.
- Architecture validation.
- Performance testing.
- Capacity planning.

- Bundling of instrumentation.
- Release certification .
- Technical aspects of deployment.
- Enterprise-level change and configuration management (including augmentation and tuning).
- System refresh planning.
- Operational Readiness Reviews (ORR) necessary to evaluate applications and system prior to production release.
- Independent testing which provides independent verification and validation of functional and non- functional requirements for systems that are deemed to have risk prior to deployment.
- Tier 3 and 4 services provided align with competency based engineering disciplines in the areas of platform, storage, database, network, interagency, datacenter, benefit systems, and health systems.

ESE Program Management Office

Overview

The ESE Program Management Office oversees internal operations of ESE, directing programmatic administrative services, including human resources activities; planning and execution of ESE budget; ESE communications program, including Web communications; staff writing and all official external correspondence; ESE Training Program, including workforce preparedness and succession planning. The ESE Program Management Office also establishes Standard Operating Procedures (SOPs) for programmatic processes and manages SOP compliance. Processes work on behalf of the Executive Director ESE and provide oversight of all ESE functions, managers and departments.

Capacity and Performance Engineering Service (CPE)

Overview

Capacity and Performance Engineering Service (CPE) provides requirements-based capacity and performance certification services to ensure IT systems meet or exceed all customer acceptance criteria and requirements and perform and operate as efficiently as possible in production. CPE works collaboratively with the OI&T development project teams on analysis of capacity and performance engineering issues throughout the system development lifecycle. CPE provides a leadership role with governance responsibility for capacity and performance evaluation at the enterprise and system platform level. See the CPE Service Areas for more information.

Systems Design & Core SE Services

Overview

Systems Design & Core SE Services is responsible for enterprise-level infrastructure engineering activities in several critical areas: Client Services, Architecture and Design, Enterprise Platform Engineering, Business Systems Engineering, and Core Infrastructure Services. The focus of these organizations is the engineering processes that ensure new and modified system components integrate efficiently into the

VA IT enterprise in order to optimize performance and satisfy customer needs. Key components of these activities include: structuring the development of IT topologies, analyses of end-to-end solutions, and the continuation of enterprise-level engineering support throughout the system lifecycle, with regard to implementation, maintenance, and disposal engineering considerations.

Enterprise Testing Service (ETS)

Overview

ETS works hand-in-hand with EPMO to provide an independent evaluation of development artifacts and product software. This evaluation helps OI&T management minimize risk of schedule delays, cost overrun, poor quality, and software failure. ETS provides test environments on which software products can be tested as well as independent evaluations of project artifacts and project software. Services falling under the category of Test Environments include: establishment of a new database with a New Test Database Request (NTDR), miscellaneous issue when there is trouble with a testing environment, database restore/refresh/backup, and user access to an environment. These services can be requested with a Test Center Service Request. Services falling under the category of Independent Evaluations include: work product reviews of project artifacts, testing observation and validation of the operation and use of the software product, and various types of testing including legacy patient safety issue (PSI) testing, risk-based independent testing, performance testing, and system integration testing.

Lifecycle and Release Management

Overview

Lifecycle and Release Management have overall responsibility for the transition of certified products that will be released to the field and lifecycle management of those products through retirement. Release Readiness: Protects the production environment and its services through the use of formal procedures and checks that govern the scheduling and deployment of changes. Change and Configuration Management: Establishes and manages enterprise change and configuration management processes for production deployments. Lifecycle and Release Management verifies the configuration health of deployments, consistent with OI&T strategies and standards. Lifecycle Management: Ensures that each product or infra-structure project is effectively managed throughout its lifecycle; it includes establishing processes that influence system cost and efficiencies for all artifacts from product inception through retirement.

ESE Technology Innovation Program Office

Overview

The Technology Innovation Program is responsible for continually evolving the Information Technology (IT) roadmap as it pertains to IT acquisition, to assure a robust standards-based infrastructure, maximize industry competition, avoid vendor lock situations, negotiate and manage Enterprise License Agreements, and apply rigorous license management practices across the Department of Veterans Affairs (VA) IT environment. TIP helps mitigate vendor lock risks and ensures alternative approaches to existing products are regularly evaluated. It will continually drive innovation by identifying alternative approaches and products to existing methods. The program office staff will monitor market trends, collect internal requirements, determine the enterprise product set and develop a technology road map.

ESE Telecommunications Engineering & Design

Overview

The mission of the ESE Office of Telecommunications Engineering and Design (Telecom) is to set the agency's enterprise level telecommunications strategy and policy, to implement VA and Federal telecommunications policies agency-wide, and to oversee the nationwide delivery of telecommunications services (voice, video, and data). Telecom is responsible for telecommunications policies, procedures, and strategic planning; OneVA WAN engineering, standards, architecture; radio frequency, spectrum management; secure communications policies and capabilities; telecom transport services orders (via FTS2001 and Networx contracts); voice infrastructure provisioning (including PBX and VoIP systems); call center infrastructure engineering, implementation and management. This office ensures that VA's telecom infrastructure meets the growing and evolving needs of the agency's staff and the veterans they serve. It is committed to providing dependable and cost-effective telecommunications services with appropriate privacy and security across the entire department.

National Service Desk

Overview

The National Service Desk (NSD) manages all IT Tier 1 Service Desk functions within OI&T; the primary functions of the Service Desk are incident and problem control, life cycle management of all service requests, and communicating with the customer. NSD Functions as first-line support for resolution of issues related to enterprise applications, systems, and other resources. NSD is responsible for service disruption and outage reporting, information dissemination, and data collection. NSD ensures a high-level of customer satisfaction by managing customer requests, incidents, and problems.

Functions and Activities

- Delivering a proactive, knowledgeable and reliable service at first point of contact, offering advice and support for centrally provided IT services.
- Offering a variety of contact methods to suit our customer's needs, including telephone, email and self-service.
- Supporting and developing our staff to ensure we deliver an excellent quality service.
- Working with stakeholders to understand the needs of our customers.
- Continually developing and improving our services and processes.
- Taking positive action to maintain a high level of customer satisfaction.

Service Desk Operations (SDO)

Overview

Service Desk Operations (SDO) is responsible for providing all VA customers a single point of contact for Information Technology inquiries, support and communication. Focus is to provide 24 X 7 X 365 support for all VA functions; Veterans Health, Veterans Benefits, Education, Data Center, Security, VA Central Office, etc..

NSD is staffed in various locations throughout the United States, with each location incorporating groups providing various functional support areas.

Service Support Operations (SSO)

Overview

Service Support Operations (SSO) is responsible for the implementation and underlying operational support of Service Desk Operations. SSO Provides technology support including: managing the IT Service Management system, the Automated Call Distribution system (ACD) as well as SharePoint management. The Metrics and Analysis Team is responsible for management and auditing of all measures. It is also responsible for quality reviews. The Knowledge Management Team is responsible gathering all application knowledge, and developing/implementing associated training programs. Resource Management develops, plans, coordinates, and manages essential business, administrative, and logistical **Functions and Activities** of NSD.

IT Service Management

Overview

IT Service Management (ITSM) is responsible for SDE's work intake process, capital planning, budget programming and execution, and cost containment. ITSM is also responsible for enterprise project management, acquisition coordination, and communications and performance metrics.

Business Services and Communications

Overview

Business Services and Communications provide support for contracts, human capital management, task coordination, communication, performance reporting and analysis, and field administrative support.

Program Administration Office

Overview

Program Administration Office (PPPM) services to SDE by employing standard, industry-proven processes, techniques, tools, and templates based upon PPPM best practices and in compliance with the OI&T Project Management Accountability System (PMAS). PAO also manages SDE activities to design and provision infrastructure solutions for application development projects.

Resource Planning

Overview

Resource Planning provides planning, analysis, and execution of SDE budget including OMB preparation and reporting, multi-year programming, budget build and execution accounting to enable effective and efficient management of IT Resources.

Authorities

Information Technology Management Reform Act of 1996 Title 40
Clinger-Cohen Act of 1996
P.L. 104-106

38 USC

Veterans Identity and Credit Security Act of 2006 (HR 5835)

E-Government Act of 2002

Federal Information Security Management Act 2002 (FISMA)

The Federal Records Act of 1950 (44 US §3101)

The Freedom of Information Act, as amended 5 U.S.C. 522

The Government Paperwork Elimination Act of 1998

Government Performance Results Act (GPRA) of 1993

Government Management Reform Act (GMRA) of 1994

P.L. 109-114, Military Quality of Life and Veterans Affairs Appropriations Act of 2006

OMB Circular A-11, Part 7

OMB Circular A-130

OMB Circular A-130 Revised

OMB Circular A-11 Part 7 Section 300

OMB Circular A-11, Section 5

U.S.C. 44 § 3506

Rehabilitation Act of 1973

Veteran Benefits Improvement Act of 2008 Privacy Act of 1974

Health Insurance Portability and Accountability Act

VA Directive 4900

P.L. 109-461 Title IX

Office of Enterprise Integration

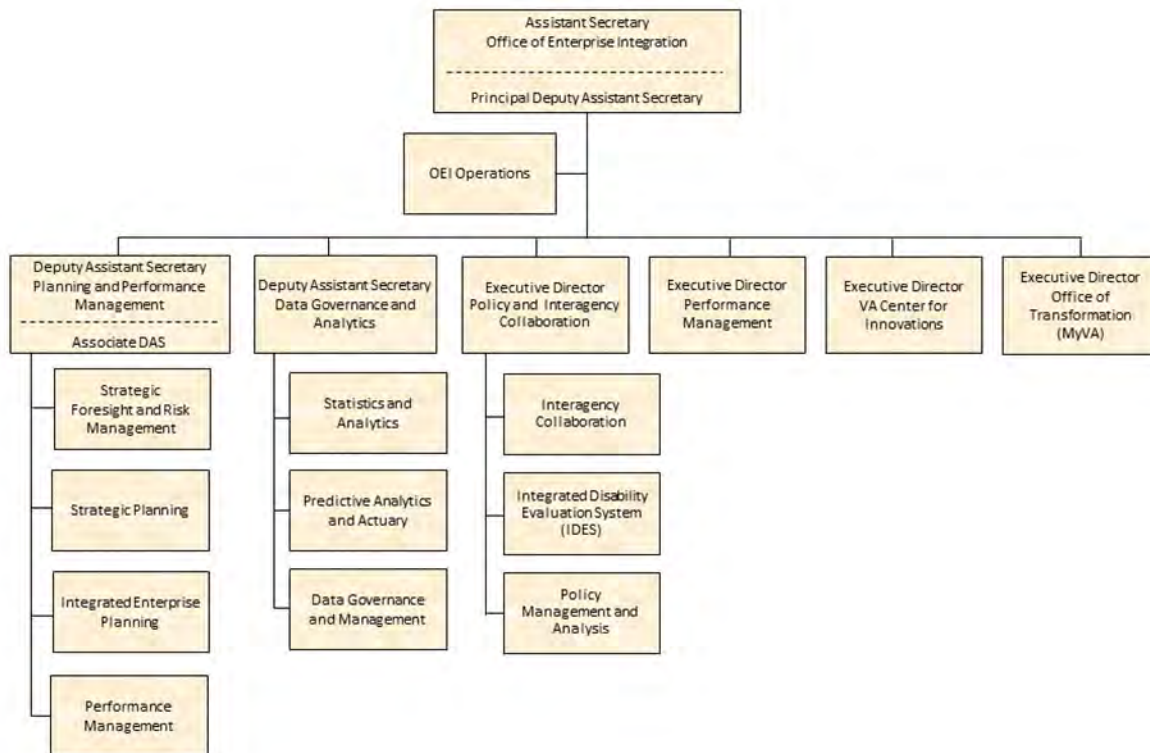


Figure 21 - Office Of Enterprise Integration Organization Chart

[Click here for the alternate representation of the chart](#)

Mission Statement

The Office of Enterprise Integration (OEI) orchestrates and leads the continuous improvement of Veterans and employee experience through effective enterprise integration of people, processes, technology; innovations; and maturing organizational management capabilities.

Office of the Assistant Secretary for Enterprise Integration

Overview

The Office of Enterprise Integration (OEI) leads the Departmental efforts in:

- Strategic and future foresights
- Strategy and strategic planning
- Integrated enterprise planning
- Enterprise risk management
- Performance management

- Policy management and analysis
- Policy research
- Transformation and innovations
- Data analytics and statistics
- Actuarial science
- Data governance
- Interagency coordination and collaboration

Authorities

38 U.S.C. Part I § 308

Office of Planning and Performance Management

Overview

The Office of Planning and Performance Management (OPPM) leads the Department's strategic future foresight and assessment; coordinates business strategy development; integrates mission requirements; conducts forward-thinking strategic planning to address long-range issues; and ensures integration of business requirements and aligning the planning and execution activities of the Department's programs and initiatives. OPPM is also responsible for managing VA's enterprise risk management framework that provides the necessary governance, communications, training, processes, and tools to effectively identify, assess, address, and monitor risks, enabling VA leadership to make informed decisions and focus priorities that make the best use of resources. OSPPI enables VA's senior leaders to maintain a consolidated, timely, and robust understanding of both known and emerging risks facing the Department, as well as how these risks are being addressed.

Functions and Activities

- Orchestrates and manages the Department's Strategic Operating Model/Manage for Results process to drive management activities and integration across the Department.
- Conducts environmental scanning to understand the nature and pace of change and identify likely future opportunities and challenges for Veterans and the VA; producing the Department's annual Strategic Environmental Assessment (SEA).
- Applies continuous environmental scanning and analysis to identify, assess, and monitor strategic level risks and opportunities; coordinates with other risk offices and the Office of Management and produces the annual Department's Risk Profile to fulfill requirements in OMB Circular A-123.
- Applies strategic foresight methodologies (alternate futures, scenario-based analysis, etc.) to guide policy and shape strategy decisions, developing Futures Analyses for the Department's senior leaders, strategic planning community and other stakeholders.

- Fosters collaborative strategic studies within VA and across federal agencies, academic institutions, and think tanks, to include leading the development of the Federal Foresight Community of Interest.
- Manages the development, refinement, and execution of the Department's Quadrennial Strategic Planning Process. Chairs the Department's cross-organizational Strategic Planning Team which coordinates the development and oversees execution of the Department's strategic plan.
- Develops bi-annual Department Agency Priority Goals (APG) in coordination with relevant VA stakeholders.
- Provides guidance, support, and expertise to assist the Administrations' and Staff Offices' internal strategic planning efforts so that they align to and implement the Department's strategic plan.
- Produces annual planning guidance to refine and update the strategic guidance articulated within the VA Strategic Plan.
- Conducts the biannual Strategic Reviews as mandated by OMB Circular A-11 which reports on the Department's progress towards the VA Strategic Plan strategic objectives. Develops the mid-year brief and the end of year report which is included in the Annual Performance Review (APR).
- Administers the Monthly Management Review (MMR) which enables VA leadership to review program progress, resolve performance problems, and assist leadership in focusing on top priorities and problems within the context of performance, budget, and workload results.
- Oversees the quarterly status reporting process to OMB for the APGs.
- Develops and oversees the development and implementation of the Department's Annual Performance Plan and Report to OMB.
- Responsible for the governance and management necessary to identify, evaluate, mitigate, and monitor the VA's operational and strategic risk as required by OMB Circular A-123.
- Manages and organizes the Department's portfolio of performance metrics and indicators coordinating departmental performance within VA plans, strategies and reports.
- Coordinates integrated enterprise mission planning (horizontal integration).
- Leads and manages VA's enterprise business architecture.
- Develops, maintains, and facilitates VA's governance process to enhance strategic decision-making in accordance with SECVA/DEPSECVA/COS guidance. Administratively supports the conduct and reporting of the Department's primary governance body, Monthly Management Review.

Authorities

38 U.S.C. Part I § 308

38 U.S.C. Chapter 11

Government Performance and Results Modernization Act of 2010, Section 2

Strategic Planning Amendments, Section 5

Federal Government Agency, Priority Goals, Section 10

38 U.S.C. § 308(b)(3)

VA Directive 0326

VA Directive 0212

Office of Data Governance and Analytics**Overview**

The Office of Data Governance and Analysis (DGA) is responsible for providing data management, data analysis, and business intelligence capabilities to inform VA-wide decision making. DGA acts as an authoritative clearinghouse for the collection, analysis, and dissemination of statistics about Veterans and VA programs. It also provides predictive analysis, actuarial services, and data-driven forecasting capabilities to inform decision-making in the Department.

Functions and Activities

- Conducts data analytic services and products to support VA planning, policy analysis, reporting, and decision making activities.
- Provides mapping and geospatial analytics services and products to support VA planning and decision making activities.
- Performs actuarial analysis and modeling to project future Veteran population and their demographic characteristics to support VA budget, strategic planning, financial reporting, and policy making.
- Produces the Annual Actuarial Liability Report for VA Compensation, Pension, and Burial Programs and the VA Medical Malpractice Liabilities which are required to be included in the VA's Consolidated Financial Statements.
- Manages the collection and dissemination of official Veteran statistics for the Department.
- Leads the Department's effort to implement and manage VA's data governance and data stewardship programs and open data initiatives.
- Maintains the official VA statistic website and managing over 800 annual requests for VA statistics from the public.

Office of Policy and Interagency Collaborations**Overview**

The Office of Policy and Interagency Collaboration (OPIC) leads and manages the Department's policy management process and provides policy analysis support to the Secretary and VA senior leadership. It

oversees the VA's policy research and collaboration activities with strategic partners (other federal agencies, academia, think tanks, and ally countries). OPIC serves as the VA lead on issues pertaining to interagency collaboration and coordination with Federal partners (DoD, SSA, HUD, DOL, Commerce, etc.).

Functions and Activities

- Manages the Department's policy and delegation of authority processes.
- Maintains a centralized repository of directives, handbooks, regulations, delegation authority, etc.
- Develops, maintains, and oversees execution of VA's Strategic Policy Agenda.
- Conducts enterprise-wide policy formulation, analysis, implementation, and evaluation.
- Fosters collaborative Veteran-centric policy research within VA and across federal agencies, academic institutions, and think tanks to enhance Veteran policy research and analysis.
- Manages the day-to-day operations of VA's Institute of Medicine Task Force.
- Manages the development of the VA Sync Matrix and Strategic Calendars through the VA Knowledge Management System (VAKMS).
- Publishes and maintains the Department's Functional Organization Manual (FOM).
- Facilitates the development and integration of joint policies and programs between VA and Department of Defense (DoD) and other agencies.
- Provides oversight for the coordination and implementation of joint VA-DoD programs and policies as they relate to activities of the VA-DoD Joint Executive Committee (JEC).
- Coordinates and facilitates a Department-wide perspective in all VA-DoD collaboration activities and initiatives.
- Provides planning and support for multiple VA-DoD governance bodies, such as the joint VA/DoD Secretarial Meetings, VA-DoD JEC, and Wounded, Ill and Injured Committee (WIIC).
- Provides oversight of the VA/DoD Integrated Disability Evaluation System (IDES) and for streamlining the VA-DoD disability evaluation process through continuous process improvements.
- Assists VA/DoD stakeholders in improving the overall effectiveness and efficiency of IDES for Service members and Veterans.
- Develops and maintains metrics for tracking the performance of IDES sites.
- In coordination with DoD, develops and monitors the execution of the VA-DoD Joint Strategic Plan (JSP) to synchronize these activities.

- In coordination with DoD, develops and publishes the VA-DoD Annual Report to Congress on VA-DoD collaboration issues.

Authorities

38 U.S. Code § 320 - Department of Veterans Affairs-Department of Defense Joint Executive Committee
 38 U.S. Code § 8111 - Sharing of Department of Veterans Affairs and Department of Defense health care resources

38 U.S.C. Part I, Chapter 3 § 320

VA Decision Memorandum, 11/15/10, Subject: Integrated Disability Evaluation System (IDES) Command and Control (VAIQ 7045557)

National Defense Authorization Act for Fiscal Year 2008, Section 1644, Authorization of Pilot Program to Improve the Disability Evaluation System of the Armed Forces

VA Decision Memorandum, 9/23/13, Subject: Veterans Employment Initiative Task Force (VEITF Governance and Joint Strategic Plan Guidance)

“Employment of Veterans in the Federal Government,” Executive Order 13518, 11/09/09.

“Veterans Opportunity to Work to Hire Heroes Act of 2011” (P.L. 112-56, §§ 201-265, 125 Stat. 712-733 [“VOW Act”])

VA Directive 0211, Functional Organization Manual Management (FOM)

VA IOM Task Force Framework

VA IOM Task Force Process Flowchart

Office of Performance Improvement

Overview

The Office of Performance Improvement is responsible for leading enterprise-wide lean management strategy and implementation to enable a culture of continuous performance and outcome improvement through employee engagement.

Functions and Activities

- Responsible for enterprise performance improvement strategy, policies, training standards, governance, and implementation coordination.
- Leads and manages all VA Performance Improvement Council activities.
- Coordinates the utilization of internal VA capabilities in Program Management, Lean, Six Sigma, Human-Centered Design, and Systems Engineering to support key management challenges and performance improvement efforts.

Authorities

P.L. 114-223

VA Center for Innovations

Overview

The VA Center for Innovation (VACI) manages strategy, policy, and lead VA innovations ecosystem and diffusion of innovative best practices. VACI identifies, prioritizes, funds, tests, and evaluates the most promising solutions to the Department’s most important challenges. VACI’s goal is to increase Veterans’

access to VA services; improves the quality of services delivered; enhances the performance of VA operations, and reduces or controls the cost of delivering those services that Veterans and their families receive.

Functions and Activities

- Advises SECVA and VA senior leadership on proven and promising innovations to address strategic challenges to VA transformation.
- Executes all aspects of the annual Industry Innovation Competitions, including marshaling VA leadership to identify top priorities, selecting innovations for funding and implementation, overseeing development and/or pilot implementation, and evaluating outcomes of the projects undertaken.
- Manages, in partnership with VHA and VBA, the annual Employee Innovation Competitions, including marshaling VA leadership to identify top priorities, advising the selection of innovations, overseeing development and/or pilot implementation, and evaluating outcomes of the projects undertaken.
- Executes prize challenges under the America COMPETES Act of 2011 and, when appropriate, special projects focused on near-term, high-impact opportunities.
- Administers the Center's Innovation Fellows program and Entrepreneur-in-Residence program.
- Provides guidance and sponsorship of the VA Innovators' Network.
- Serves as the sponsor and manager of independent innovation relationships with the private sector through use of cooperative research and development agreements

Authorities

P.L. 114-223

Office of Transformation

Overview

The Office of Transformation leads and manages breakthrough transformation initiatives and activities in the Department.

Functions and Activities

- Orchestrates the planning of VA's priority transformational initiatives.
- Coordinates management oversight of the transformation initiatives execution.
- Manages and supports all activities related to the Secretary's MyVA Advisory Committee.
- Support the development of strategic partnerships with private sector and other external organizations to improve services to Veterans.

Authorities

P.L. 114-223

Office of Operations, Security, and Preparedness

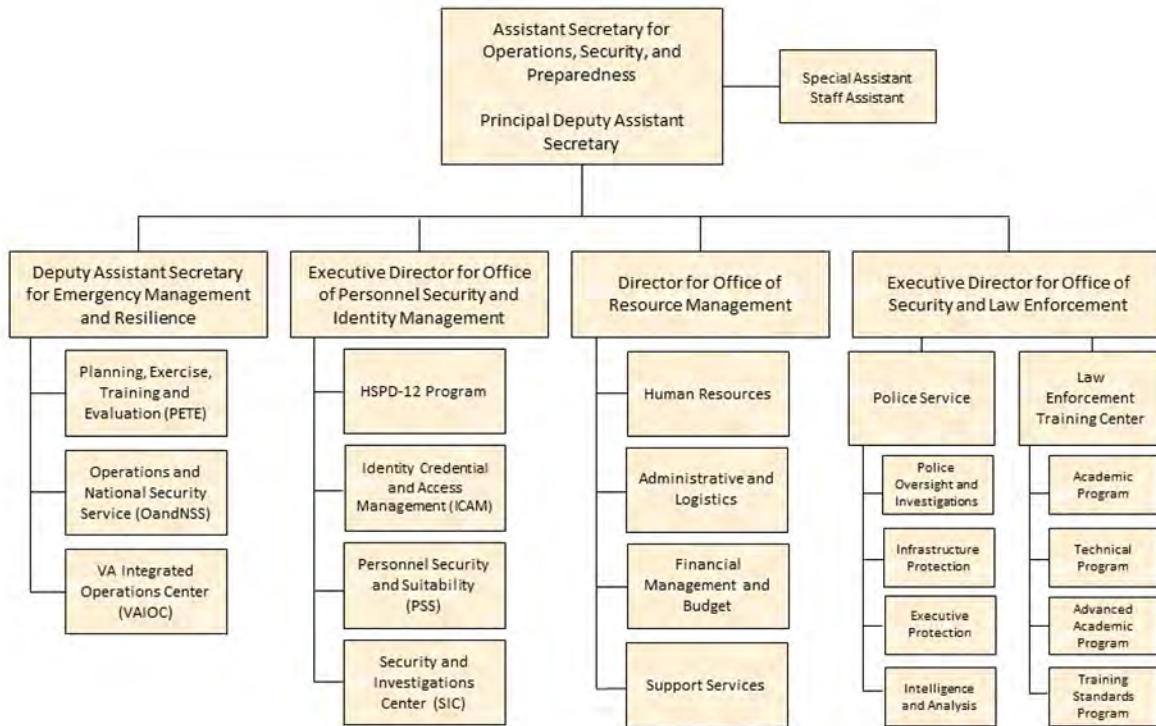


Figure 22 - Office of Operations, Security and Preparedness Organization Chart

[Click here for the alternate representation of the chart](#)

Office of the Assistant Secretary for Operations, Security, and Preparedness

Mission

Office of Operations, Security, and Preparedness (OSP) will raise preparedness of the Department of Veterans Affairs to provide services and protect people and assets continuously and in time of crisis.

Overview

The Assistant Secretary for OSP coordinates VA's emergency management, preparedness, identity management, physical security, personnel security and suitability, police services and law enforcement activities, and ensures compliance and resource management in the OSP so the Department can continue to perform mission-essential functions under all circumstances across the spectrum of threats. OSP directs and provides oversight for VA's overall operations for planning, response, and security and law enforcement programs in support of the National Response Framework, Homeland Security Presidential Directive (HSPD) 12, and other related executive orders and Federal regulations.

Functions and Activities

Office of the Deputy Assistant Secretary for Emergency Management and Resilience

Overview

The Office of Emergency Management and Resilience (OEMR) provides policy and program oversight for the Department's National Security Portfolio. This portfolio is comprised of Emergency Management, Continuity of Operations (business continuity) and Government, National Security Information Management, Insider Threat, and Intelligence and Counterintelligence Programs. OEMR ensures the Department can effectively manage consequences associated with crisis through resilient capabilities and foster an operational environment that will enable the Department to return to normal operations as quickly as possible. In addition, OEMR is the Department lead for the Department of Veterans Affairs' (VA) fourth mission and serves as the integration layer for Department capabilities that can be leveraged to manage emergencies at the local, state, tribal, or federal levels.

Functions and Activities

- Oversees the management and operations of VA's contingency sites, which include VA's Integrated Operations Center, primary continuity site, reconstitution site, devolution site, and other Department level contingency sites.
- Serves as the Federal Intelligence Coordination Office (FICO) lead for the Department.
- Manages the Department's Insider Threat Program.
- Oversees the training and evaluation of VA Senior Leadership as well as Administration and Staff Office national security personnel to support government-wide resilience requirements.
- Manages VA's Order of Succession Program to ensure the continuity of Senior Leadership.
- Oversees the integration, safeguarding, and management of Intelligence Community resources residing in the Department.
- Manages the Department's Counterintelligence Program.
- Ensures the viability of all Department continuity facilities and the infrastructure required to support operations in an all hazards threat environment.
- Oversees the management of the Department's security administration programs ensuring that they are structured to prevent compromise of classified national security resources.
- Provides oversight of the Department's National Security/Emergency Preparedness Communications.

Planning, Exercises, Training, and Evaluation

Overview

The Planning, Exercises, Training, and Evaluation (PETE) Division is responsible for continuity planning and associated training. PETE is the Department's lead for whole of government planning as it pertains to continuity of operations and government. As an integrator, PETE assists in identifying all Administration and Staff Office requirements and manages overall coordination to ensure these requirements are incorporated in the interagency planning efforts. On a daily basis, PETE manages the four elements of the Federal Continuity Program which include senior leadership training, support staff training, continuity facilities, and continuity communications. The following functional tasks are executed by the PETE Division:

Functions and Activities

- Develops department policy and plans for Continuity of Operations, Continuity of Government and Enduring Constitutional Government programs.
- Serves as the Department's lead for all Continuity of Operations, Continuity of Government and Enduring Constitutional Government actionable planning efforts.
- Represents the Department on various interagency planning groups and ensures that the Department's equities are included in whole of government planning, response, recovery and mitigation actions. Directs continuity planning efforts to ensure all Department plans are coordinated, robust, and functional and support execution of the Primary Mission Essential Function (PMEF), Mission Essential Functions (MEF), and internal Agency Essential Functions (AEFs).
- Represents the department with the interagency on various preparedness topics IAW the National Response Framework (NRF).
- Manages the Department's Test, Training, Exercise, and Evaluation Program to enhance VA's emergency management and continuity capabilities.

Operations and National Security Services

Overview

The Operations and National Security Services Division (ONSS) serves as the Department's lead regarding National Security operations/engagements and interfaces with the interagency. ONSS provides policy and oversight for the Department's special security, secure and emergency preparedness communications, Insider Threat, Counterintelligence and Intelligence Community support programs. The following functional tasks are executed by the ONSS Division:

Functions and Activities

- Maintains and ensures the readiness of the Department's secure communications systems (voice, data, and video) and Sensitive Compartmented Information Facilities (SCIFs).

- Manages total life cycle requirements for the Department's National Security/Emergency Preparedness (NS/EP) communication systems.
- Serves as the Department's lead for all national security issues and coordinates the Department's position with the interagency.
- Manages the Department Insider Threat Program and represents the Department with the National Insider Threat Task Force (NITTF).
- Manages Intelligence and Counterintelligence Programs within the Department and coordinates with the Intelligence Community (IC).
- Coordinates emergency preparedness communications requirements to ensure compliance with National Communication System Directive (NCSD) 3-10.
- Provides policy development, oversight, and management of the special security programs including access to classified information and Sensitive Compartmented Information (SCI).
- Provides policy oversight and program management for classified intelligence information to include transmission, safeguarding, and destruction.
- Provides Communications Security (COMSEC) management and oversight for the Department's cryptologic material and equipment portfolio to ensure secure communications.
- Provides Government Emergency Telecommunications Service (GETS) and Wireless Priority Service (WPS) oversight and management.
- Ensures Department is properly represented with Department of Homeland Security regarding Shared Resources (SHARES) High Frequency (HF) Radio Network oversight and management.

VA Integrated Operations Center

Overview

The Veterans Integrated Operations Center (VAIOC) is the Department's national level hub for situational awareness, a common operating picture, information fusion, information dissemination, planning, and communications in support of VA crisis management, operational coordination, and disaster response. The VAIOC operates continuously with representatives d by all Administration and Staff Offices. During times of crisis, the VAIOC serves as the consequence management center for Senior Leadership to coordinate with the interagency and to allocate resources and efforts where needed within the Department. The following functional tasks are executed by the VAIOC:

Functions and Activities

- Conducts operational reporting of incident events and threats by obtaining, validating, coordinating, and disseminating critical information, decision support products, and notifications for situational awareness and/or action.

- Manage crisis action processes by coordinating and implementing crisis monitoring and reporting, while facilitating communication and information flow within VA and with Federal interagency partners for enhanced response and recovery operations.
- Maintain a Geographic Information Systems (GIS) capability which supports routine operations, crisis management and Senior Leader decision making.
- Manages and tracks requests for VA operational support by identifying, sourcing and coordinating for the deployment of internal capabilities in response to federally declared disaster response and operational contingencies.
- Coordinates VA information sharing and operational support for DHS designated special security events.
- Supports continuity of essential functions at the national level by maintaining a continuity capability including alert, notification, and deployment of personnel to pre-identified continuity management sites.
- Deploys liaisons to Federal homeland security and disaster response partners to facilitate information flow and enhanced coordination.
- Provide strategic guidance which supports VA emergency management planning.
- Represents the Department on interagency planning groups and ensures VA equities are properly managed.
- Participates as a full partner in interagency planning and coordination to ensure the ability of VA to support Federal disaster response.
- Conducts planning in support of emerging internal and interagency contingency requirements.

Authorities

32 CFR Parts 2001 and 2003 Classified National Security Information

Title 18 U.S.C. § 793, 794, 798– Crimes and Criminal Procedure – 793 - Gathering, transmitting or losing defense information, 794 - Gathering or delivering defense information to aid foreign government, 798 - Disclosure of classified information

EO 10450– Security Requirements for Government Employment

EO 12333 – United States Intelligence Activities

EO 12968 – Access to Classified Information

EO 13526 – Classified National Security Information

EO 13587 – Structural Reforms to Improve the Security of Classified Networks and the Responsibility Sharing and Safeguarding of Classified Information

EO 13618 – Assignment of National Security and Emergency Preparedness Communications Functions

Presidential Policy Directive – 8: National Preparedness

Presidential Policy Directive – 21: Critical Infrastructure Security and Resilience

Presidential Decision Directive – 12: Security Awareness and Reporting of Foreign Contacts

HSPD-5 – Management of Domestic Incidents

NSPD-51/HSPD-20 National Continuity Policy

National Preparedness Goal, September 2011
 Federal Continuity Directives (FCD) 1 and 2
 National Communications Directive (NCSD) 3-10: Minimum Requirements for Continuity Communications Capabilities
 National Counterintelligence Strategy, 2016
 National Disaster Recovery Framework, September 2011
 National Incident Management System, December 2008
 National Response Framework, May 2013
 National Security Strategy, February 2015
 National Strategy for Counterterrorism, June 2011
 National Strategy for Biosurveillance, July 2012
 National Strategy for Pandemic Influenza, November 2005
 National Strategy for Pandemic Influenza Implementation Plan, May 2006
 Response Federal Interagency Operational Plan, July 2014
 Recovery Federal Interagency Operational Plan, July 2014
 Department of Veterans Affairs Emergency Preparedness Act of 2002
 Disaster Relief Appropriations Act of 2013
 Post-Katrina Emergency Management Reform Act of 2006
 Public Health Security and Bioterrorism Preparedness and Response Act of 2002
 Robert T. Stafford Disaster Relief and Emergency Assistance Act amended, April 2013
 Sandy Recovery Improvement Act of 2013
 The Homeland Security Act of 2002
 The National Security Act of 1947, as amended
 VA and DOD Health Resources Sharing and Emergency Operations Act amended, November 1992
 Nuclear Radiological Incident Annex March 2015
 VA Directive 0320 – Comprehensive Emergency Management Program
 VA Directive 0321 – Serious Incident Reports
 VA Directive 0322 – VA Integrated Operations Center
 VA Directive 0323 – VA Continuity Program
 VA Directive 0324 – Test, Training, Exercise, and Evaluation Program
 VA Directive 0327 – Insider Threat Policy
 VA Strategic Plan FY 2014-2020
 National Security Agency Policy Manual 3-16

Office of the Executive Director for Personnel Security and Identity Management

Overview

The Office of Personnel Security and Identity Management (OPSIM) contributes to a safe and secure environment for the Department of Veterans Affairs through ensuring trust in our VA workforce – appointees, employees, contractors, and affiliates. OPSIM enforces VA compliance with Federal personnel security and suitability statutes, regulations, and policies. It manages VA's compliance with Homeland Security Presidential Directive 12 (HSPD-12) and delivers a VA Personal Identity Verification (PIV) smartcard credential for access to Federal facilities and information systems.

Functions and Activities

- The Director of OPSIM serves as the executive lead for the VA major initiative (MI) of Preparedness, ensuring the preparedness of VA to meet emergent national needs, as directed in the VA Strategic Plan for FY 2011-2015.
- OPSIM establishes and enforces VA compliance with personnel security and suitability policies and regulations through the Personnel Security and Suitability (PSS).
- The Director of OPSIM is responsible for the implementation of Homeland Security Presidential Directive 12 (HSPD-12), Policy for a Common Identification Standard for Federal Employees and Contractors, dated February 3, 2011, to ensure the use of the PIV credential is required as the common means of authentication for access to VA's facilities, networks and information systems.
- The Security and Investigations Center (SIC) processes and adjudicates background investigations for all moderate risk, high risk public trust, and national security positions for federal employees and contractors.
- The Identity, Credential, and Access Management (ICAM) program management office will support and establish a consistent and VA-wide solution for identifying VA users for the purpose of managing access to resources while ensuring an individual's privacy.
- The Director of OPSIM serves as the lead for identity management for VA, managing the Department-wide process of ensuring that people who access VA facilities and IT systems are identity-proofed, trusted, and credentialed at the appropriate level to carry out the work they are assigned.

Homeland Security Presidential Directive 12

Overview

Homeland Security Presidential Directive 12 (HSPD-12) was issued August 27, 2004 to create a common interoperable crypto-based identification standard for federal employees and contractors for accessing federally-controlled facilities and federal information systems. VA will ensure full implementation and maintenance of HSPD-12 by standardizing the on-boarding, monitoring, and off-boarding process to ensure the safety of VA employees, contractors and affiliates; implement the Personal Identity Verification (PIV) card as the standard process for provisioning logical access to VA information systems (LACS) and standardize Physical Access Control Systems (PACS) to VA facilities to ensure the safety and security of Veterans and eligible beneficiaries, volunteers, employees, and visitors; and fully implement the automated ICAM functions to meet all HSPD-12 requirements. HSPD-12 provides a very high level of assurance of identity to facilitate this trust.

Functions and Activities

- Ensures VA's compliance with Homeland Security Presidential Directive 12 (HSPD-12) and manages the development and implementation of the Department's HSPD-12 Program.

- Ensures VA achieves OMB milestones and objectives for Government-wide HSPD-12 compliance, including PIV card issuance, Physical Access Control Systems (PACS), and Logical Access Control Systems (LACS).
- Conducts coordination and reports compliance to OMB providing monthly reports on VA's HSPD-12 program.
- Fiscally program and define a HSPD-12 budget line for implementation of HSPD-12 in the annual VA PPBE process in coordination with OI&T.
- Provides daily oversight and program management for the VA-wide HSPD-12 program, to include execution of the approved operating plan and associated work breakout structures, integrated master schedule, and risk register.
- Provides policies (directives) and processes (handbooks) that define VA requirements for compliance with HSPD-12 and applicable Federal standards.
- Ensures training, oversight and compliance for all VA PIV card issuance facilities, including assessment and accreditation in accordance with National Institute of Standards and Technology (NIST) requirements and Federal Information Processing Standards (FIPS).
- Provides cognizance of PIV card issuance for all eligible VA employees, contractors, and affiliates throughout the VA enterprise.
- Ensures training and certification for all Personal Identity Verification (PIV) role holders in accordance with Federal Information Processing Standards.
- Ensures and provides oversight for life-cycle management of the PIV Card Management System as a key authoritative digital identity database in accordance with the Federal Identity Credential and Access Management Roadmap.

Identity Credential and Access and Management

Overview

The Identity, Credential, and Access Management (ICAM) Program Management Office (PMO) will support and establish a consistent and VA-wide solution for identifying VA users for the purpose of managing access to resources while ensuring an individual's privacy. The ICAM solution will implement a robust and automated system providing centralized authentication, authorization, and provisioning services for internal as well as external users. One of the first initiatives is to implement an end-to-end ICAM Onboarding, Monitoring, and Off-boarding solution to provide a uniform, effective, efficient and robust process that ensures VA employees, contractors, healthcare profession trainees, volunteers, and affiliates who require access to VA facilities and systems are identity-proofed, credentialed, and provided access to systems at the appropriate level upon assumption of duties. The program will also ensure users are continuously monitored during their tenure, and will ensure access is terminated, deactivated, or suspended when it is no longer needed.

Functions and Activities

ICAM advocates for the formulation of standardized business practices to eliminate delays in the on-boarding process and implementation of enhanced procedures to more effectively track and monitor the VA workforce in compliance with Federal rules, laws and regulations.

- Plans, analyzes, and establishes the requirements for an effective VA enterprise IT system that integrates and proactively manages the on-boarding, monitoring, and off-boarding processes to optimize performance, accountability, and quality control.
- Collaborates with internal VA stakeholders to define relevant work flow processes and establish requirements to create a uniform, efficient, and effective process to manage the end-to-end career life cycle of employees, contractors, and affiliates during their tenure with the VA.
- Interfaces with internal and external stakeholders to identify best practices for adoption throughout the VA enterprise.
- Ensures system compliance with identity authentication requirements and tracking of position sensitivity and eligibility/access to sensitive and classified information as it relates to monitoring of VA employees, contractors, and affiliates in order to protect VA assets.
- Develops the requirements to integrate disparate legacy IT systems throughout the VA to achieve greater efficiency in the on-boarding and off-boarding of employees, contractors, and affiliates and performs a comprehensive gap analyses to enhance the on-boarding and off-boarding processes.
- Develops the requirements to ensure employees, contractors and affiliates are continuously monitored during their tenure with the VA and their physical and logical access to VA facilities and networks is terminated, deactivated, or suspended when it is no longer required.
- Program advocate for the formulation of standardized business practices to eliminate delays in the on-boarding process and implementation of enhanced procedures to more effectively track and monitor the VA workforce in compliance with Federal rules, laws and regulations.

Personnel Security and Suitability Service

Overview

Personnel Security and Suitability (PSS) Service provides department wide personnel security and suitability program policy, implementation, oversight, and training to ensure the safety and security of our nation's veterans, visitors, employees and facilities. PSS' scope and reach touches every member of the VA workforce at the start of the hiring process and required reinvestigation intervals.

Functions and Activities

- Writes, coordinates, and distributes policies and processes that define VA requirements for compliance with applicable statutes, Executive Orders, and Federal regulations for all VA employees, contractors, and affiliates.

- Conducts training, oversight, and compliance of VA offices that perform personnel security and suitability functions or tasks in accordance with the Office of Personnel Management (OPM) program review standards.
- Ensures that each appointee, employee, contractor and affiliate assigned to VACO is fingerprinted and receives the appropriate background investigation commensurate with the designed risk and sensitivity level.
- Coordinates requirements and acts as liaison with OPM Federal Investigative Service and other supporting organizations for personnel security.
- Conducts the security clearance appeals board as required.
- Coordinates with other agencies and exchanges personnel security and suitability information with the Office of Personnel Management (OPM), Office of the Director of National Intelligence (ODNI), and other agencies.
- Serves as the VA lead for policy development and oversight of VA's Personnel Security and Suitability Program.
- Exercises authority, direction and control over VA Administrations regarding policies and procedures related to the suitability, national security and fitness adjudication process.
- Conducts training, oversight, and compliance of Administrations that perform personnel security and suitability functions.
- Ensures an effective pre-screening and adjudicative process within VA.

P.L. 97-174

Veterans Administration and DoD Health Resources Sharing and Emergency Operations Act, 1982

38 U.S.C. § 8011A

Veterans Access, Choice, and Accountability Act of 2014 (VACAA)

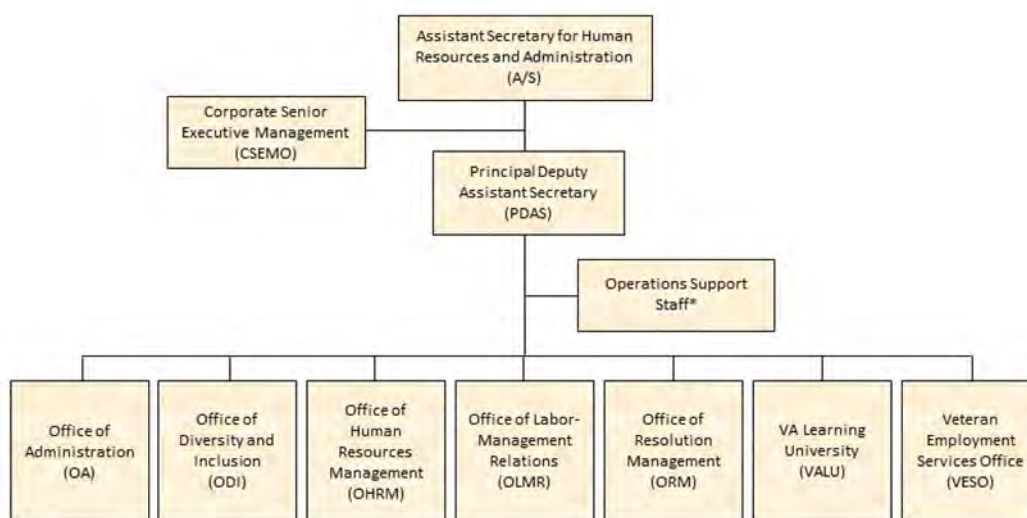
Occupational Safety and Health

Manages the national oversight of VA's OSH and Workers' Compensation (WC) programs. This involves oversight and support of the three Administrations and staff office OSH programs and Departmental policies.

Functions and Activities

- Manages VA's OSH and WC programs nationwide. Provides oversight of VA's OSH programs, develops education and administrative programs that enhance workplace safety and health, WC case management, and liaises between VA and other organizations for OSH and WC matters.
- Encourages the creation and establishment of new Department-wide programs, such as the Pharmacy Benefits Program, to benefit VA employees and reduce costs to VA.
- Oversees resolution of safety and WC issues.

Office of Human Resources and Administration



*Operations Support Staff Functions: Budget and Risk Management; Program Management/Acquisition Support; MyVA Integration; HR&A Communications; Strategic Planning and Organizational Performance

Figure 23 - Office of Human Resources and Administration Organization Chart

[Click here for the alternate representation of the chart](#)

Mission

The mission of the Office of Human Resources and Administration (HR&A) is to lead the development and implementation of human capital management strategies, policies, and practices to cultivate an engage, proficient, and diverse workforce, one that will continue to transform and improve the delivery of services to Veterans and their families.

Office of the Assistant Secretary for Human Resources and Administration

Overview

HR&A supports the execution of VA's Strategic Objective 3.1 (*Make VA a Place People Want to Serve*) and Strategic Objective 1.1 (*Improve Veteran Wellness and Economic Security*) through the following programs and services: enterprise-wide, competency-based workforce development for VA employees and leaders; strategic consultation and policy guidance for VA to attract, recruit, develop and retain high-performing employees; life-cycle management of the VA's Senior Executives; development and implementation of programs to support Veteran recruitment, and VA retention and reintegration; prevention and resolution of workplace disputes; policy development in Equal Employment Opportunity (EEO) and diversity and inclusion, workforce analysis, outreach, retention, education and communications; policy guidance and bargaining with five (5) major unions that represent over 270,400 VA bargaining unit employees; and, customer-focused support services that create a safe and productive work environment.

HR&A is comprised of eight program offices and an operations support team which provides budget and risk management, acquisitions, strategic planning, performance evaluation and communications services.

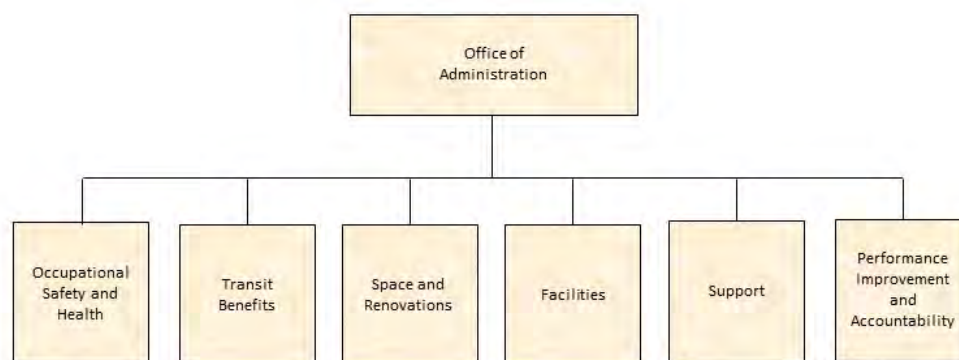


Figure 24 - Office of Human Resources Administration - Office of Administration

[Click here for the alternate representation of the chart](#)

Office of Administration

Overview

The Office of Administration (OA) works through partnerships to provide customer-focused support services that create a safe and productive work environment. OA provides support services to VA Central Office (VACO) organizations and employees.

Functions and Activities

- Manages the Department's Occupational Safety and Health (OSH) and Workers' Compensation (WC) programs.

- Directs facilities management efforts for VACO, including building services, rent/lease reconciliation and payment, Emergency Preparedness and notifications, personnel accountability, support for VACO, and records management.
- Provides support services to VACO organizations and employees including transportation, parking, mail operations, property management, and media services.
- Directs VA Transit Benefit Program policy and coordination of fare distribution.
- Manages and directs the space and renovation needs for the VACO campus.
- Directs the institutionalization, integration, and oversight of the Lean Six Sigma methodologies for HR&A.

Transit Benefits

Overview

The program is designed to improve air quality, reduce traffic congestion, and conserve energy by encouraging employees to commute to and/or from work by means other than single-occupancy motor vehicles.

Functions and Activities

- Directs VA Transit Benefit Program policy nationwide.
- Coordinates application submission and fare media distribution nationwide and oversees fare media distribution in the National Capitol Region (NCR).
- Conducts periodic nationwide audits and provides advice and recommendations to field transit managers and administrators on cases of fraud and abuse.

Space and Renovations

Overview

Manages the space needs of VACO organizations within the National Capital Region and the space inventory. This includes leasing additional space and renewing leases through GSA.

Functions and Activities

- Oversees all electrical work, painting, construction, and related alterations work in VACO space.
- Manages all OA funded workstations, conventional furniture, and seating in the VACO building. Services include cleaning, repairs, replacement, reconfigurations, modifications, and new purchases.
- Manages the space needs of VACO organizations within the National Capital Region (NCR) including redesign, consolidations, and space reallocations.
- Administers leases through the General Services Administration (GSA) within the NCR and works with GSA on lease renewals and terminations.

Facilities

Overview

Provides a wide range of facility related services to the tenants of the various VACO buildings such as building maintenance, recycling, and janitorial services. Related service lines include records management and resource management (budget execution and formulation).

Functions and Activities

- Oversees the GSA contract for buildings management in VACO, including interior and exterior building maintenance and janitorial services (mold remediation, elevator repairs and maintenance), recycling program, conference room scheduling, lock and key control, exterior signage, and VACO safety monitoring.
- Administers Safety and Emergency Preparedness Program for VACO and provides emergency support to VACO campus facilities, which includes continuity of operations planning (COOP), VA Personnel Accountability System (VA-PAS) and emergency liaison for VACO.
- Provides records management support, oversight and guidance, including set-up, close-out, and disposition (packaging, shredding, archiving) of official records and files.

Support

Overview

Provides logistical and asset management support to VACO and surrounding VACO facilities. This includes the VACO Health and Wellness Centers, Media Services, and the Property Management Division which oversees transportation, VACO mail services, Executive Correspondence, and property accountability.

Functions and Activities

- Oversees the Interagency Agreement with Federal Occupational Health, which includes six health units, the VACO fitness center and the Employee Assistance Program.
- Oversees VACO's asset management program (equipment inventory listing of nonexpendable, non-IT property); assigns survey officers/board for lost, stolen or damaged property; manages accountability and control of VACO non-IT assets from acquisition through disposal; issues property passes; provides transportation support; processes White House/executive correspondence; and manages mail operations, warehouse operations (receiving) and labor support.
- Provides audiovisual, photography, graphics/exhibit design and video support for VACO organizations.

Performance Improvement and Accountability

Overview

Oversees the institutionalizing, integrating, and oversight of Lean Six Sigma (LSS) methodologies for HR&A, as well as Lean Six Sigma training within HR&A.

Functions and Activities

- Integrates and oversees the Lean Six Sigma methodologies for HR&A.
- Tracks and maintains oversight of all Continuous Process Improvement projects and provide progress updates to leadership to include cost savings, resource, and project profile.
- Operates the Client Service Center (VACO) to include promulgating center policies, strategies, and other customer service protocols.

Authorities

P.L. 103-3

5 U.S.C. 8101, et seq.

VA Directive 5810

P.L. 91-956

EO 12196, § 2-201 (c)

Title 29 CFR 1960.6 (a)

VA Directive 7700 3 a (2).

Presidential POWER Initiative: Protecting Our Workers and Ensuring Reemployment (FR Doc. 2010-18176)

VA Directive/Handbook 0633

EO 13150

P.L. 103-172

5 U.S.C. 7905

Title 18 U.S.C. 1001

26 U.S.C. 132(f)(2)

Federal Acquisition Regulation (FAR)

VA Directive/Handbook 7002, 7002-1

VA Directive/Handbook 7240, 7241

VA Directive 6103

VA Directive/Handbook 6301

VA Directive 6340

VA Directive 6609

FMR Subchapter B

FMR Subchapter G

FAR Part 13

VA Acquisitions Regulation

Federal Code Regulation

OMB Circular A-11

5 CFR

VA Handbook 5011

Government Performance and Results Act of 1993 (GPRA)

Government Performance and Results Act - Modernization Act of 2010 (GPRA-MA)

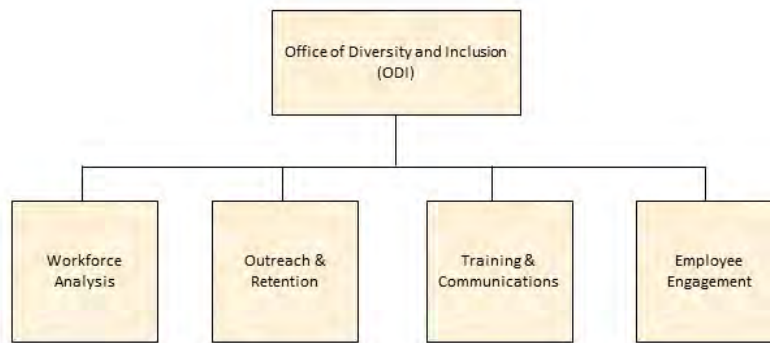


Figure 25 Office of Human Resources Administration - Office of Diversity and Inclusion

[Click here for the alternate representation of the chart](#)

Office of Diversity and Inclusion

Overview

The Office of Diversity and Inclusion (ODI) serves to build a diverse workforce and cultivate an inclusive workplace to deliver the best services to our Nation's Veterans and their families. ODI does this through national policy development in Equal Employment Opportunity (EEO), Diversity and Inclusion, workforce analysis, outreach, retention, training, education, and communications. ODI also leads VA's enterprise-level Employee Engagement efforts.

Functions and Activities

- Advises and supports the Assistant Secretary for HR&A in workforce diversity and workplace inclusion issues.
- Supports the Secretary, Deputy Secretary, Under Secretaries and Assistant Secretaries in their actions to achieve and sustain a diverse workforce and inclusive workplace.
- Develops, implements, and manages VA's Employee Engagement activities.

Workforce Analysis

Overview

Develops consolidated VA-wide reports for the EEO Commission – Management Directive (MD) 715; Office of Personnel Management - Federal Equal Opportunity Recruitment Programs (FEORP) and Department of Education - White House Initiative (WHI) on Minority-Serving Institutions and other WHIs.

Functions and Activities

- Performs barrier analyses (a process of reviewing VA's policies and procedures to identify and eliminates impediments in selection, promotion, recruitment, and retention of protected class individuals) in conjunction with the Workforce Analysis Team.

- Analyzes trends and develops barrier statements and action plans for the VA MD 715 Report.
- Provides technical assistance and training, and creates analytical applications for managers and supervisors to evaluate diversity initiatives.

Outreach & Retention

Overview

Develops and monitors outreach and retention initiatives and programs.

Functions and Activities

- Provides consultative services and integrates organizational development initiatives.
- Administers VA Special Emphasis Programs (e.g., Hispanic Employment Program, Black Employment Program, Lesbian, Gay, Bisexual, Transgender Program, and Disability Employment Program).
- Administers the National Diversity Internship Program and the Workforce Recruitment Program for College Students with Disabilities for talent acquisition, and provides centralized funding for both programs.
- Manages a central repository for tracking reasonable accommodation (RA) requests and coordinates the centrally-administered RA fund.

Training & Communications

Overview

Delivers strategic diversity and inclusion training and communications.

Functions and Activities

- Develops VA-wide policy statements, strategic plans and annual reports in the area of EEO, diversity and inclusion.
- Produces standard and customized diversity and inclusion training, and assesses the impact of learning on organizational performance.
- Manages and provides administrative support for the VA Diversity Council to address cross-cutting initiatives, and produces and disseminates communications products.

Employee Engagement

Overview

Provides the foundation and coordination to energize VA's Employee Engagement (EE).

Functions and Activities

- Utilizes analysis of the Agency Priority Goal - Quarterly Pulse Surveys, the Federal Employee Viewpoint Survey (FEVS) and VA's All Employee Survey (AES) results to identify and address EE and leadership-related issues revealed in the surveys.

- Provides EE strategies, tools, insight, and guidance to leaders and employees across VA with the goal of improving engagement at all levels.
- Leads EE-focused initiatives and coordinates actions among VA Administrations to more rapidly socialize EE concepts throughout the workforce.

Authorities

5 U.S.C. 7201

5 CFR Part 720, Subpart B & C

EEOC Management Directive 715

VA Directive 5975 “Diversity and Inclusion”; 5975.1 Processing request for Reasonable Accommodation from employees and applicants with disabilities

EO 13171 – Hispanic Employment in the Federal Government

EO 13270 – Tribal Colleges and University (July3, 2002)

EO 13515 – Increasing Participation of Asian Americans and Pacific islanders in Federal Programs

EO 13532 – Promoting Excellence, Innovation, and Sustainability at Historically Black Colleges and Universities

EO 13548 – Increasing Federal Employment of Individuals with Disabilities

EO 13583 – Establishing a Coordinated Government-wide Initiative to Promote Diversity and Inclusion in the Federal Workforce

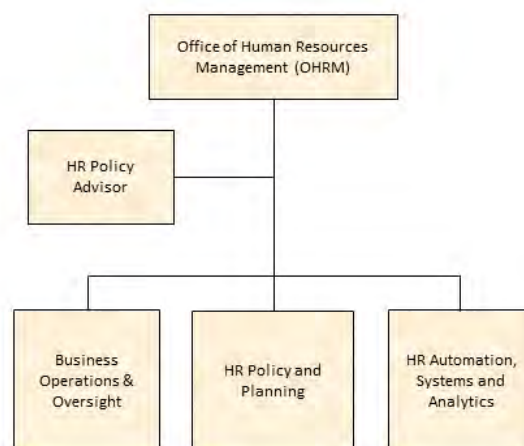


Figure 26 - Office of Human Resources Administration - Office of Human Resources Management

[Click here for the alternate representation of the chart](#)

Office of Human Resources Management

Overview

The Office of Human Resources Management (OHRM) provides human resources, strategic consultation and guidance to its customers. These services enable VA to attract, recruit, develop and retain high-performing, engaged employees, resulting in quality services to Veterans and their families. Specifically, OHRM develops policies and provides guidance with regard to staffing, recruitment, classification, pay and leave administration, performance management and recognition, work-life and employee benefits.

Additionally, OHRM manages VA's HR information systems (HRIS) and supports enterprise workforce planning.

Functions and Activities

- Provides VA human capital management and assesses the effectiveness of Department-wide HR programs and policies.
- Trains HR Professionals on both Title 5 and Title 38 HR lifecycle functions.
- Provides VA with policy and operational support on employee relations, performance management, recruiting & staffing, classification & compensation, work life & benefits, and workforce planning.
- Develops and sustains VA's HR information systems.

Business Operations & Oversight

Overview

Provides HR operational support to VA Central Office (VACO) organizations, oversight of HR implementation and compliance across all of VA's HR Offices, and tailored HR training for VA's HR Professionals.

Functions and Activities

- Oversees VA human capital management and merit system compliance by assessing the effectiveness of Department-wide HR programs and policies through on-site evaluations of field HR programs; reports findings to the Administrations.
- Provides HR-focused courseware and instruction to the VA's nearly 5,000 HR Professionals for both Title 5 and Title 38 employees.
- Supports VACO with HR lifecycle support to include classification, recruitment, employee and labor management, and performance management services.
- Manages VA's Child Care Subsidy Program.

HR Policy and Planning

Overview

Provides policy and guidance in support of VA's efforts on recruiting & staffing, employee relations & performance management, position classification & compensation, and work life & benefits.

Functions and Activities

- Develops department-wide HR policy and guidance to include directives, handbooks, human resources management letters and other guidance on all HR functional areas such as employee relations, performance management, compensation, classification, hours of duty and leave, benefits, accountability systems, etc.

- Designs and implements programs to promote work-life balance as well as health and wellness for all VA employees.
- Provides employee relations and performance management policy and services.
- Provides VA policy and services on position classification and employee compensation matters.

HR Automation, Systems, and Analytics

Overview

Provides VA personnel with industry leading HR services and reporting capabilities in order to optimize strategic management of human resources in support of VA's mission.

Functions and Activities

- Manages the design, development and implementation of HR-Smart, VA's new automated human resources information system. HR-Smart will replace the legacy Personnel and Accounting Integrated Data (PAID) system and improve HR business processes.
- Identifies VA-wide workforce planning needs and builds workforce planning capabilities that may be leveraged throughout VA to inform decision-making.

Authorities

Chief Human Capital Officers Act of 2002

P.L. 107-296

5 U.S.C. §§1401 and 1402

5 U.S.C. § 512

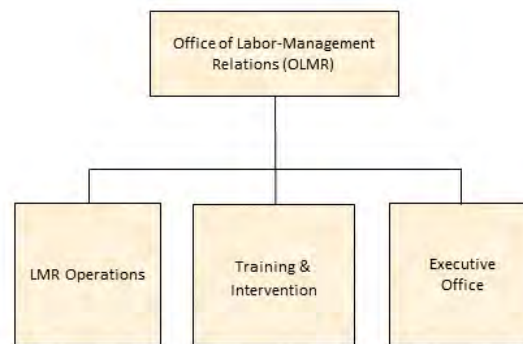


Figure 27 - Office of Human Resources Administration - Office of Labor-Management Relations

[Click here for the alternate representation of the chart](#)

Office of Labor- Management Relations

Overview

The Office of Labor-Management Relations (OLMR) facilitates a collaborative working environment by promoting labor-management cooperation and working with labor organizations to improve the delivery of service to Veterans and their families.

Functions and Activities

- Oversees all national negotiations for the five national unions within VA.
- Collaborates with the Department's five national unions and other members of VA's executive-level leadership to ensure the work of the organization is strategically linked to the direction of the business of the Department and all components.
- Ensures that the Department's LMR programs and practices are consistent with all applicable laws, regulations and Presidential Executive Orders (EO).
- Co-chairs the VA National Partnership Council (NPC), which is a venue for sharing information, pre-decisional engagement, and building an effective relationship with our national labor partners. The NPC also advises the SECVA and Senior VA leadership on initiatives that impact employees, and serves as an exemplary partnership council to promote cooperative labor-management relations across the Department.
- Periodically assesses the effectiveness of LMR programs and the state of labor-management cooperation throughout the Department.

LMR Operations

Overview

Plans, coordinates, and oversees all LMR operations and manages the LMR program at the national level.

Functions and Activities

- Provides oversight of LMR specialists who serve as labor relations subject matter experts and as an informational point of contact for all VA geographic locations.
- Advises and provides expert guidance to customers on preventing and resolving grievances, unfair labor practices (ULP), labor litigation and responding to questions on the interpretation of national collective bargaining agreements, labor statutes, case law, Executive Orders (EO) impacting labor relations and OPM regulations.
- Evaluates VA Directives, handbooks, program guides, information letters, or other policy issuance to determine whether a national bargaining obligation exists or national notification is required.
- Provides national policy notifications for information only or bargaining to national union representatives.
- Provides expert advice and subject matter expertise on national policy matters and Department bargaining obligations resulting from new policy initiatives while serving as management's lead representative during the notification and negotiation process with all VA national union representatives.
- Disseminates and interprets Department policies and procedures for the VA LMR Program.

Training and Intervention

Overview

Promotes effective and collaborative labor-management relationships at all levels of the Department. Helps facilitate the Department's success in managing the workforce while meeting its national labor relations obligations.

Functions and Activities

- Collaborates with VA Learning University (VALU) and Office of Information and Technology (OIT) to continually improve the joint labor relations training modules available to all VA employees through the Talent Management System (TMS) website.
- Develops and delivers jointly created VA/AFGE Master Agreement training for VHA, VBA, and NCA facilities; develops and delivers Creating Labor-Management Forums (EO 13522) training in partnership with the Federal Labor Relations Authority (FLRA).
- Represents the Department in all national union grievances.
- Represents the Department in arbitrations regarding all national collective bargaining agreements and interpretation of the Federal Labor Statute.
- Conducts joint LMR interventions.
- Collaborates with the National Center for Organization Development (NCOD) regarding the effectiveness of local labor-management relations as well as the effectiveness of local labor-management forums.
- Represents the Department before the FLRA and the Federal Service Impasses Panel (FSIP) on LMR matters.

Executive Office / Business Office

Overview

Provides critical support to the needs of the organization through effective management and strategic initiatives. The objective is to focus on business affairs, acquisitions, administrative services, planning operations, and oversight of the LMR website.

Functions and Activities

- Maintains current and effective labor relations guidance and information on the LMR website.
- Develops approaches and initiatives for integrating VA's core values and characteristics into organizational processes.
- Identifies and leverages leading practices.
- Supports budget formulation and execution to include acquisition requirements.

- Manages executive event planning management supporting contractual VA and Union Partnership engagements.

Authorities

VA Directive 5023

EO 13522

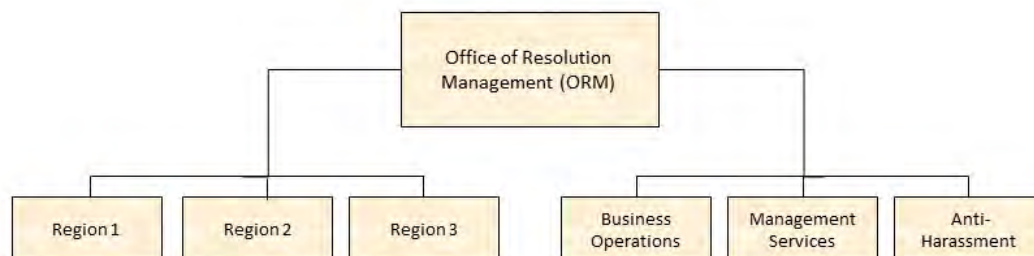


Figure 28 - Office of Human Resources Administration - Office of Resolution Management

[Click here for the alternate representation of the chart](#)

Office of Resolution Management

Overview

The Office of Resolution Management (ORM) works to promote a discrimination-free work environment focused on serving Veterans by preventing, resolving, and processing EEO discrimination complaints in a timely and high-quality manner. ORM processes EEO complaints for VA employees, applicants for employment, and former employees and provides oversight for the VA's Anti-Harassment Office to ensure allegations of workplace harassment are handled in a fair and effective manner. Complaint processing services include counseling, Alternative Dispute Resolution (ADR), procedural determinations, and investigations. These services are provided through a nationwide network of six (6) district operations offices serving three (3) geographic regions: Region 1: two North Atlantic District offices, Region 2: a Midwest District and a Southeast District office; and Region 3: a Continental District and a Pacific District office. ORM also administers the ADR program throughout VA to manage conflict and prevent and resolve disputes through mediation, conflict coaching, group facilitation, and assessments. These assessments provide business intelligence of the workplace to aid and facilitate leaders in responding to existing or potential workplace issues.

Functions and Activities

- Offers programs, such as conflict management, ADR training, and assessments, that ensure employees and managers understand the characteristics of a healthy work environment and have the tools to effectively engage and manage workplace conflict thereby preventing disputes and complaints.
- Provides consultative services and resources, such as neutral third-party facilitators, mediators, and coaches, to assist the workforce in resolving workplace disputes and EEO complaints.
- Offers Resolution Support Center to inform and discuss options for resolving workplace disputes and to advise managers on issues that often lead to EEO complaints .

- Provides EEO discrimination complaint processing services to VA employees, applicants for employment and former employees which include counseling, investigation, and procedural final agency decisions.
- Develops programs to improve the overall management of EEO discrimination complaint processing services within VA, including training for employees, managers, and supervisors on the EEO complaint process (includes training on harassment and retaliation).
- Ensures VA compliance with final decisions on EEO complaints and settlement agreements, and fully investigates claims for compensatory damages. Prepares Federal and congressionally mandated reports, such as the No FEAR Act and the Senior Managers Report.
- Coordinates the receipt and referral of allegations of discrimination raised by Veterans with respect to Federal conducted or assisted programs and activities under Title VI and Title IX of the Civil Rights Act, the Age Discrimination Act of 1975 and the Rehabilitation Act of 1973.

Business Operations

- Provides support to ORM's mission and critical functions by providing discipline-focused expertise in EEO, establishing policy, monitoring compliance, driving data science, and developing IT infrastructure

Management Services

- Provides quality customer service support to over 250 employees assigned to three regions and six field sites geographically disbursed across the U.S. in the following areas: human capital management/employee engagement, financial management, space and facility support and contracting liaison assistance

Anti-Harassment

- Provides policy and oversight for the Department's Anti-Harassment Program.
- Promptly addresses employee concerns and enhances management effectiveness and transparency.

Authorities

P.L. 105-114 P.L. 107-174
 29 CFR 1614
 EEOC Management Directive 110
 Administrative Dispute Resolution Act
 VA Directive 5977
 VA Directive 5978
 38 CFR 15.170

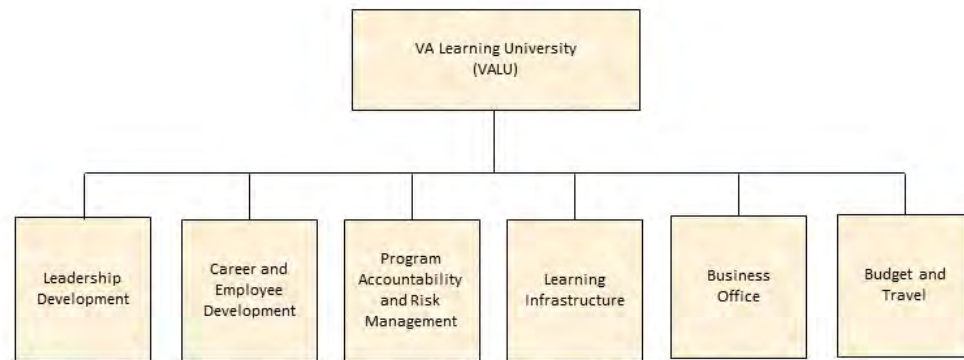


Figure 29 - Office of Human Resources Administration - VA Learning University

[Click here for the alternate representation of the chart](#)

VA Learning University

Overview

VA Learning University (VALU) provides enterprise-wide, competency-based workforce development for VA employees and leaders. Sets the overall vision and strategy for the University, communicates the same to all stakeholders, and establishes accountabilities for execution of the mission and the strategy.

Functions and Activities

- Supports VA's training goals and objective of managing and improving VA operations so as to deliver seamless and integrated support.
- Supports Human Resources and Administration's strategic goal of driving VA transformation through strategic human capital engagement, development, and talent acquisition.
- Provides innovative competency-based training, education and development so that our VA-wide workforce is capable, confident and delivers quality products and services to our Nation's Veterans and their families.

Leadership Development

Overview

Designs, develops, executes, and manages programs to develop VA leaders at every stage of the employee lifecycle through a systematic, deliberate, and integrated approach.

Functions and Activities

- Assesses, designs, develops, implements, and evaluates Leadership development courses to develop VA leaders at every stage of the employee's career.
- Manages an innovative, diverse set of programs that provides a leadership pipeline for VA, such as Leaders Developing Leaders (LDL), Executive & Senior Leadership Development Programs

(e.g., SESCDP & SLC), Leadership VA (LVA), Virtual Aspiring Leaders (vALP), and Supervisor Training (New Supervisors Essentials - NSE).

- Collaborates with VALU Training Requirements to support the Leadership Development Course Catalog.
- Serves as the Co-Chair of the Leadership Development Subcommittee of the Training Leaders Council.

Career and Employee Development

Overview

Manages instructional systems design to deliver unique learning opportunities to all VA employees. Manages career and employee design and development (CEDD) programs.

Functions and Activities

- Ensures system design addresses common competencies that apply to all or cross-organizational sections of the VA workforce, the development of employee knowledge and skills that improves technical abilities and encourages improvement of employee educational levels in alignment with organizational goals and objectives.
- Promotes and manages an array of CEDD programs such as: My Career at VA, Pathways, Training Assessments and Modeling, and All Employee Competency Development.
- Collaborates with VALU Training Requirements to support CEDD Course Catalog.
- Serves as the Co-Chair of the Mandatory Training Subcommittee of the Training Leaders Council.

Program Accountability and Risk Management

Overview

Provides oversight, consistency, accountability, evaluation, and assessment of program performance outcomes and measures.

Functions and Activities

- Establishes and supports the execution of VALU's acquisition and program management policies, plans, processes and standard operating procedures.
- Provides oversight and evaluation of VALU projects/programs.
- Coordinates with HR&A components and external contracting activities in support of programs.
- Monitors and tracks implementation of VALU's acquisition strategy and performance measures.
- Oversees and integrates risk management processes and implements internal controls.
- Conducts comprehensive training and curriculum evaluation and assessment.

- Conducts process improvement activities leveraging Lean and Lean Six Sigma tools.
- Serves as the Co-Chair of the Training Evaluation Quality Assurance and Analysis (TEQAAG) Subcommittee of the Training Leaders Council.

Learning Infrastructure

Overview

Develops and sustains a learning infrastructure that promotes ongoing career and personal development through seamless access to processes and tools.

Functions and Activities

- Provides innovative tools to support learning and employee development.
- Ensures access and availability of VALU products and services.
- Establishes governance for the use and integration of enterprise-wide learning tools.
- Establishes data management strategies to support decision analysis.
- Provides program management for enterprise-wide learning delivery and support.
- Serves as the co-chair of the Learning Technology and Innovation Subcommittee of the Training Leaders Council.

Business Office

Overview

Provides oversight and operational support in the areas of training requirements, strategic communications, human resources, policy and process improvement, logistics, and executive correspondence.

Functions and Activities

- Solicits, identifies, captures, and supports training requirement collection VA-wide. This includes Leadership and All Employee Catalog requirements.
- Creates, designs, develops, and implements strategic VALU communications VA-wide.
- Provides external HR liaison for staffing and recruitment, classification and position management, performance management and awards, requests for personnel actions, employee and labor relations, PIV badge sponsorship, onboarding and off-boarding, and also work life and benefits services coordination.
- Creates, reviews, and modifies VALU policy, procedures, and staff training.
- Provides logistics, supply, emergency preparedness, and space requirements.
- Reviews, prepares, and edits executive correspondence.

- Plans and coordinates the monthly Training Leaders Council.
- Serves as the co-chair of the Training Requirements Subcommittee of the Training Leaders Council.

Budget and Travel Office

Overview

Provides support in the areas of financial facilitation of resources and travel to members of VALU to effect superior operational efficiency.

Functions and Activities

- Constructs and advocates credible, defensible, and executable budgets to contribute to cost-effective performance of VALU.
- Ensures full accountability and control over the financial assets of the VA Learning University and provide timely, accurate, and useful financial information for decision support.
- Develops a financial and budgeting strategy and monitor the University's financial performance in accordance with the federal practices of life-cycle cost estimating, cost analysis and expenditure planning.
- Ensures compliance of financial policies and operating procedures.
- Establishes, maintains, controls, and reports out VALU funding requirements and management.
- Enables effective decision-making through accurate and timely financial tracking and reporting.
- Provides budget counseling and support for all VALU programs.

Authorities

Title 5 U.S.C. Chapter 14, 41

VA Directive 5015

VA Handbook 5015-1

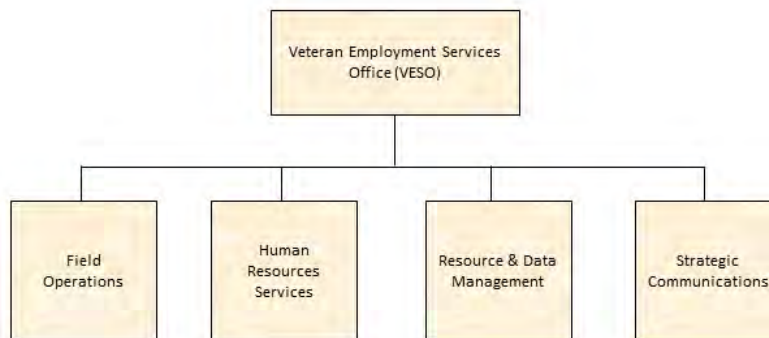


Figure 30 - Office of Human Resources Administration - Veteran Employment Services Office

[Click here for the alternate representation of the chart](#)

Veteran Employment Services Office

Overview

The Veteran Employment Services Office (VESO) was created in 2011 in support of Executive Order 13518, *Employment of Veterans in the Federal Government*. The VESO mission is to develop and implement innovative and comprehensive programs, procedures and services to support VA Veteran recruitment, retention and reintegration.

Functions and Activities

- Helps identify and prepares eligible service members transitioning to the civilian workforce.
- Provides consultative services to various Federal agencies concerning Veterans staffing issues and legal considerations.
- Gathers and manages data related to the Veteran community.
- Maintains an active presence with the community of Veteran-centric stakeholders.

Field Operations

Overview

Veteran employment specialists located in the five districts across VA identify hiring needs and recruit Veterans to fill targeted positions and ongoing vacancy requirements at VA.

Functions and Activities

- Attends nationwide outreach events to build awareness and advise Veterans, HR officers, hiring managers, and HR specialists of the federal non-competitive hiring options and VESO services.
- Assists Veterans in preparing resumes and completing employment application packages.
- Provides follow-up support and advocacy for job placement and retention.
- Manages VA's Disabled Veteran Affirmative Action program.

Human Resources Services

Overview

VESO's team of HR and training specialists provides consultative services for VA and other federal agencies on Veteran employment policy, the appropriate application of Veterans preference, and the use of special hiring **Authorities** to increase the number of Veterans in the civilian workforce.

Functions and Activities

- Provides HR support in the areas of Veteran staffing at VA and other Federal agencies through the Feds for Vets initiative.

- Oversees the Uniformed Services Employment and Redeployment Rights Act (USERRA) compliance and case management for the Department.

Resource and Data Management

Overview

Provides and analyzes Veteran employment data to contribute to workforce planning initiatives, identify trends and manage VESO's strategic retention program.

Functions and Activities

- Monitors and tracks VA's performance toward meeting annual Veteran employment goals monitored by OPM.
- Develops reports on Veteran workforce trends and processes VESO's customer requests for Veteran workforce data.
- Manages the newly developed VA-wide Veteran retention strategy that includes Veterans Affinity, Veterans Mentoring and Veterans Onboarding programs.

Strategic Communications

Overview

Coordinates all outreach and communications initiatives for VESO's *VA for Vets* program.

Functions and Activities

- Manages media inquiries and coordinate interviews for customers seeking information on VESO's VA for Vets program.
- Manages all written correspondence related to VESO's VA for Vets program; coordinates all speaking engagements/briefings.
- Maintains website and social media presence to connect with Veterans and stakeholders.
- Develops and manages communications and outreach.

Authorities

Department of Veteran Affairs Office of Human Resources and Administration (HR&A) Strategic Plan FY2014-2020

Department of Veterans Affairs Strategic Plan

Executive Order 13518, November 2009 (Employment of Veterans in the Federal Government)

Office of Personnel Management's Veteran Guide

Veterans Opportunity to Work (VOW) to Hire Heroes Act 2011

Veterans Recruitment and Employment Strategic Plan for FY 2014-2017

5 CFR part 720, Subpart C (Disabled Veterans Affirmative Action Program)

5 CFR 315.705; 5 CFR 307 (Veterans' Recruitment Appointment)

5 CFR 316.302 (b)(4); 5 CFR 316.402(b)(4); 5 CFR 315.707 (Selection of term, temporary employees; Disabled Veterans)

5 CFR 213.3102(u); 5 CFR 315.709 (Schedule A; Appointment of Persons with Disabilities)

5 U.S.C. 2108 (Veterans Preference)

5 CFR 3.1 (Classes of Persons Who Can Noncompetitively Acquire Status)

38 U.S.C. 4214 (Employment within the Federal Government)

38 U.S.C. Chapter 43 (USERRA)

38 U.S.C. Chapter 31; 315.604 (Training and Rehabilitation for Veterans with Service Connected Disabilities; Employment of Disabled Veterans Who Have Completed Training Under Chapter 31 of Title 38)

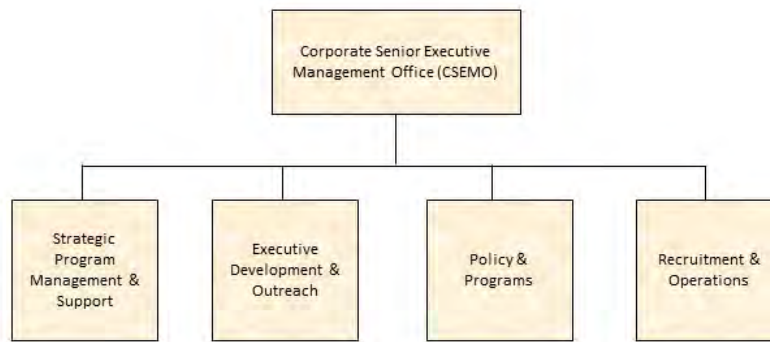


Figure 31 - Office of Human Resources Administration - Corporate Senior Executive Management Office

[Click here for the alternate representation of the chart](#)

Corporate Senior Executive Management

Overview

Corporate Senior Executive Management (CSEMO) supports the entire life-cycle management of VA's senior executives. CSEMO provides full employment services for VA's senior leaders*, Title 38 SES Equivalent appointees, members of the Board of Veterans Appeals, and consultants and experts. These services include allocation and position management, selection and retention, assessment, compensation, performance management, training and development.

* VA Senior Leaders include: Political Appointees, members of the Senior Executive Service (SES – career, non-career, limited term, and limited emergency), Senior Level (SL), and senior leader Schedule C employees.

Functions and Activities

Strategic Program Management and Support

- Provides advice and counsel to the VA senior leadership on all matters regarding the Department's senior executive workforce and its management.
- Develops and establishes VA policies and processes needed to support full life-cycle management of the senior executive workforce.

Executive Development and Outreach

- Provides corporate-level personnel services for senior executives, including onboarding and executive development programs, training and coaching, in coordination with the Administrations and Staff Offices.

Policy and Programs

- Administers an effective senior executive compensation, recognition and awards program.
- Administers and provides training for the VA-wide Senior Executive automated performance management system.
- Supports Government-wide initiatives and collaborates with others across Government to develop and deliver new senior executive programs.

Recruitment and Operations

- Manages a proactive recruitment program and manages senior executive allocations to ensure resources are aligned with VA's priorities and vacancies are filled efficiently and expeditiously.

Authorities

Executive Order on Strengthening the Senior Executive Service, December 15, 2015

Office of Personnel Management's SES Desk Guide, December 2015

Department of Veterans Affairs Strategic Plan

Department of Veteran Affairs Office of Human Resources and Administration (HR&A) Strategic Plan FY2014-2020

Veterans Affairs Handbook 5027, Senior Executive Service

5 U.S.C. § 3131.

5 U.S.C. § 2301 Merit Principles

5 U.S.C. §2302 (a)(2)(B) Prohibited Personnel Practices

5 CFR Part 214—Senior Executive Service

38 U.S.C.

Operations Support Staff

Overview

The Operations Support Staff executes HR&A business management practices that enable HR&A to deliver human capital services to the Department.

Functions and Activities

- Leads HR&A strategic planning and MyVA integration efforts.
- Monitors, evaluates, and reports on organizational and program performance, enabling VA leaders to make data-driven decisions, strengthen accountability and facilitate a culture of customer-service.
- Provides leadership, stewardship and oversight on budgetary, financial, and risk management matters. Ensures effective controls and accountability over HR&A resources.
- Provides overarching program management guidance, and also manages, facilitates and provides oversight for Human Capital acquisition strategy and efforts across HR&A.

- Provides communications expertise and support to advance the HR&A Assistant Secretary's goals in support of VA's Strategic Plan, the MyVA initiative and VA's I CARE core values

(b)(6)
(b)(2)

Office of Public and Intergovernmental Affairs

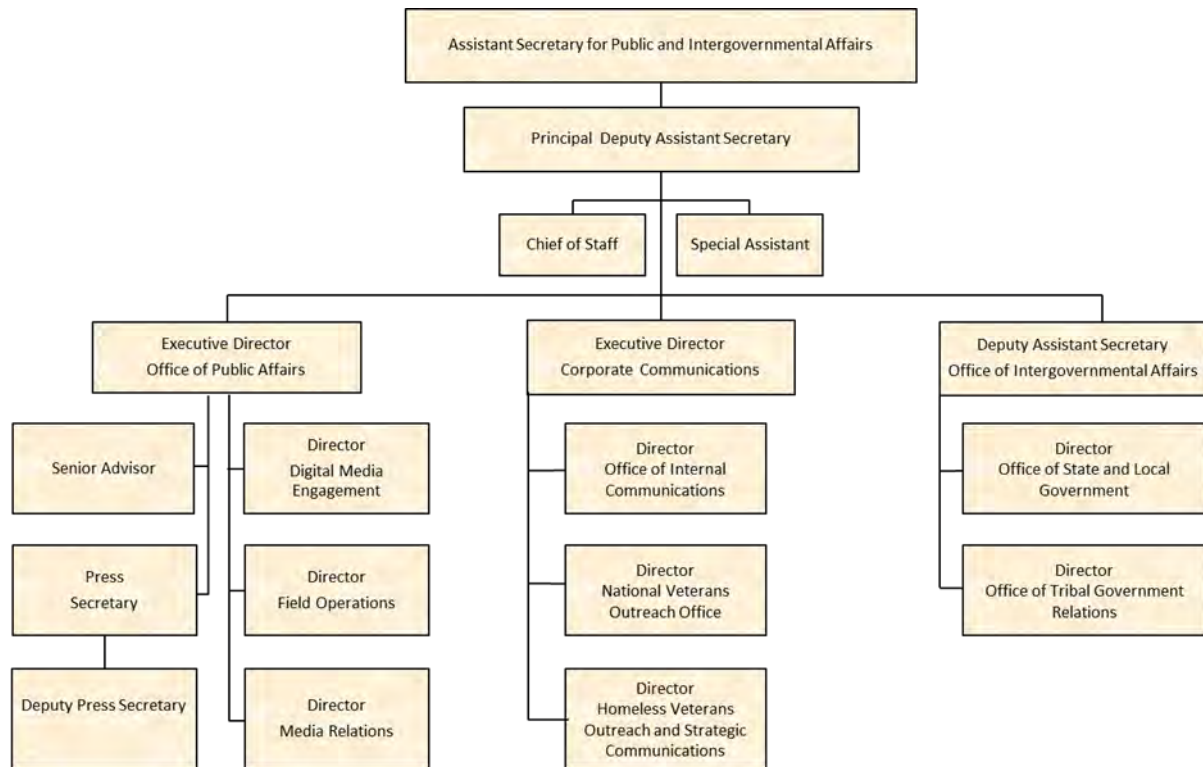


Figure 32 - Office of Public and Intergovernmental Affairs Organization Chart

[Click here for the alternate representation of the chart](#)

Mission Statement

The Office of Public and Intergovernmental Affairs (OPIA) conducts integrated and strategic outreach and engagement to build and maintain public confidence in the Department of Veterans Affairs (VA) in support of VA's strategic goals. OPIA develops, updates, and communicates the Department's key messages to engage many stakeholders and drives an integrated strategy that includes media relations, digital (online and social media), community relations, public affairs special events and strategic outreach, intergovernmental affairs, as well as Veteran engagement to educate and inform Veterans, their families, their survivors, and other beneficiaries about the benefits and care they have earned and deserve.

Office of the Assistant Secretary for Public and Intergovernmental Affairs (002)

Overview

The Office of the Assistant Secretary provides executive oversight, management, and direction to the OPIA and its subordinate activities. The Assistant Secretary oversees VA's communications and outreach programs including media relations, digital media, and special events. The Office of the Assistant Secretary includes the Principal Deputy Assistant Secretary, a Special Assistant, the Chief of Staff, and other program analysts and assistants.

Functions and Activities

- Oversees the Department's outreach and engagement communications with Veterans, their beneficiaries, the general public, VA employees, news and digital media, and other critical stakeholders.
- Develops, maintains, and communicates the Department's messages through media relations, public and intergovernmental affairs and community engagement to empower, educate and inform Veterans, their families, their survivors, and other beneficiaries about the benefits and care they have earned and deserve.
- Directs the Department's Intergovernmental, Tribal Government Relations, National Veterans Outreach Office, Homeless Veterans Outreach and Strategic Communications Office, and the Office of National Veterans Sports Programs and Special Events
- Builds trust and confidence in VA and its readiness to serve America's Veterans of all generations by building and maintaining honest relations with different audiences and articulating a truthful and transparent narrative of VA's activities.

Office of the Executive Director for Public Affairs (80)

Overview

The Office of the Executive Director for Public Affairs provides Veterans, their families, their survivors, and other beneficiaries' information through various media channels about VA benefits and programs. Through the preparation and dissemination of various communications materials, the Office provides essential information on program eligibility and operations to a variety of public entities. It maintains close liaison with media representatives and monitors print and broadcast news activity. It provides responses to inquiries concerning data and information about Department operations and policy.

Functions and Activities

Manages VACO's media relations program.

- Responds to media inquiries.
- Produces external media products (i.e., media releases, media advisories, and fact sheets).
- Coordinates integrated media responses with VACO staff, VA Directorates, and VA Administrations.
- Builds and maintains relationships with news media to facilitate ongoing dialogue and balanced news coverage.
- Provides field public affairs support to Veterans Integrated Service Networks (VISN), Memorial Service Networks (MSN), and benefits centers nationwide.
- Coordinates regional press inquiries with VACO and supported VISNs, MSNs, and benefits centers.
- Provides event support packages.

- Provides onsite public affairs support to traveling senior VACO leadership as required.
- Trains VISN, MSN, and benefits center public affairs personnel in their respective regions.
- Provides public affairs advice and counsel to VA regional leadership.
- Provides public affairs training and pre-event media preparation/coaching for senior VA personnel as well as onsite mission support.

Manages VA's primary digital media presence to educate and inform key internal and external stakeholders via digital technology.

- Maintains the Department's flagship blog, "Vantage Point."
- Manages VA's main Web governance and oversight process, portions of the va.gov Website.
- Manages VA's social media platforms (Facebook, Twitter, Instagram, etc.) and policy.
- Produces, films, and distributes timely video stories and products.
- Provides online stories to complement other VA-generated media products.
- Provides subject matter expert-level training to VACO and other internal VA organizations for online and social media strategy and execution.

Educates and informs internal audiences and key stakeholders through production and distribution of internal media products.

- Composes and publishes the "Vanguard" magazine for VA and key stakeholder organizations.
- Maintains timely and up-to-date photographic records of major VA activities and publishes them for internal organizations and personnel as well as key stakeholder use.
- Provides subject matter expert-level training and video production expertise to VACO and other VA organizations.

Provides public affairs plans, recommendations, and support to SECVA and OSVA.

- Briefs SECVA and other senior VA leaders daily on media reports and trends concerning VA.
- Provides senior advice and counsel to SECVA and OSVA on all media topics.
- Synchronizes the Department's key messages with the Office of Government Relations and other VA organizations or Staff Offices, as appropriate.
- Provides direct support to SECVA while on official travel.

Public Affairs Senior Advisor

Overview

The Public Affairs Senior Advisor is the senior federal civil service public affairs officer and coordinator for external information delivery. Public Affairs encompass the following elements: Media Relations, Field Operations, and Digital Media Engagement. Media Relations focuses on engagement, through media interviews, press conferences, news releases, and coordinated responses to query. Field Operations provides VA Central Office liaison and staff assistance on a regional basis for Veterans Integrated Service Networks (VISN), Veterans Affairs Medical Centers (VAMC), Veterans Benefits Administration (VBA) Regional Offices (RO), and National Cemeteries. Digital Media Engagement is focuses on content material for web operations through blogs and other online publications, engagement on multiple social media platforms, and measurements of effectiveness through social media.

Functions and Activities

- **Media Relations:** Manage accounts by general topics for engagement with print, television, and other electronic media outlet reporters and producers. Coordinate media engagement (i.e. interviews, press conferences, media roundtables etc.) Accept media queries and coordinate and provide responses on behalf of the Department.
- **Field Operations:** Manage media engagements on a national basis using field office personnel. Team members serve as liaison between VA Central Office and the various VA offices nationwide. Team assists and coordinates media functions in respective areas on behalf of the Department. Team members serve as public affairs representatives for the Secretary, Deputy Secretary, and other senior leaders in coordination with the Press Secretary, the Executive Director for Public Affairs, and the Assistant Secretary. Team members also provide preparation and training for public affairs officers and leaders.
- **Digital Media Engagement:** Team manages continue for various pages of the VA main webpage, produces and manages web blog, and creates and distributes a podcast from the VA Central Office. Team manages, provides guidance, and provides content to multiples on various VA controlled social media platforms including (but not limited to): Facebook, Twitter, YouTube, Instagram etc.

Office of Digital Media Engagement (80D)

Overview

The Office of Digital Media Engagement leverages existing and emergent digital communication (Web-based) technologies to provide the right information to the right VA stakeholder at the right time. Additionally, Digital Media Engagement creates and distributes various communication products designed through an integrated content delivery platform, including video, print, and online media to inform external and internal audiences of the many benefits, services, and programs available to Veterans and how they may access those benefits. It provides Department-wide technical guidance, editorial expertise, and production standardization for internal media products released by the VA.

Functions and Activities

- Digital Media Engagement creates and maintains a coordinated digital culture across the enterprise to enhance the end-user experience on the Department's primary Website, va.gov. Digital Media Engagement also produces content products for print, broadcast, and digital formats, and distributes them to VA facilities, offices, and sites for use by employees, Veterans, family members, VSOs, and community partners. The products are also used to highlight the daily work, as well as the special achievements of VA employees in delivering care and benefits to our Nation's Veterans.

Conducts outreach via digital and social media.

- Manages the department's primary content delivery system, the Vantage Point blog, by creating content, editing guest submissions and requesting specific content from Veterans, VA employees and various stakeholders to engage in current topics.
- Provides multiple, daily social media updates with valuable VA information, and connects with Veterans through comments, blogs, and discussions. Platforms include Facebook, Twitter, Instagram, and others as appropriate.
- Creates and posts digital news videos that highlight the work of VA employees and provides important information about the benefits and services that VA offers. Videos are shared via Vantage Point, YouTube, and Facebook.
- Creates photos and updates and maintains VA's Flickr site, which contains more than 28,000 photos and has more than 15.6 million views.

Enforces and standardizes social media guidelines.

- Monitors and maintains the standards of VA's Web-based social media tools.

Oversees VA Web Governance.

- Manages the Department's Web Governance Board, which is responsible for standardization and enforcement for VA's primary Web properties.
- On behalf of the Board and with the input and participation of VA's three main Administrations, Digital Media Engagement leads the standardization of VA's Web presence. Digital Media Engagement enforces VA's minimum requirements for specific Web properties and ensures compliance with mandated standards.

Educates and informs internal audiences and key stakeholders through production and distribution of key internal media products.

- Publishes VAnguard, the national employee magazine of VA, which communicates leadership's priorities to employees and shows how employees can individually contribute to mission success.
- Produces VACO daily broadcast messages, which are internal messages used to inform VACO employees of upcoming events, deadlines, retirements, etc.

- Produces “Hey VA,” a brief message intended for all VA employees, distributed daily through various VA intranet sites, VistA, and VA email networks. Focuses on employee and facility achievements, important policy changes, and Departmental initiatives.
- Provides, publishes official VA biographies for senior leaders
- Distributes key all-employee messages on individual earnings and leave statements.
- Helps develop and publish SECVA messages.
- Informs and educates external audiences and key stakeholders through the production and distribution of outreach products.
- Produces field support packages to support facility involvement in special events, activities, and programs, such as national commemorative programs (Veterans Day) and program events.
- Produces the Federal Benefits for Veterans, Dependents, and Survivors handbook (English, Spanish, digital editions), which is an annually updated handbook that provides a digest of all VA and other Federal benefits for Veterans as well as directory of all VA facilities and benefits access points. Annually ranked by Government Printing Office (GPO) as one of Top Federal publications.

Authorities

VA Directive 6515

VA Directive 6102

VA Web Governance Board Charter

Press Secretary (80)

Overview

The Press Secretary serves as a senior advisor to the Secretary and Deputy Secretary on media engagement and strategic messaging. The Press Secretary also provides departmental guidance on the messaging regarding implementation of the Secretary/Deputy Secretary policies, plans, and goals to serve Veterans, their families, their survivors, and other beneficiaries. The Press Secretary maintains a direct coordination line with the Secretary and Deputy Secretary.

Functions and Activities

- Functions as a liaison to the Office of the Secretary regarding significant media activities and travel support and independently considers a broad spectrum of factors when making recommendations including public, congressional, and public policy stances.
- Coordinates directly with the secretary and senior VA staff, White House officials and other stakeholders on Veterans policy or special projects involving topical Veterans’ issues.
- Provides the Office of Public and Intergovernmental Affairs (OPIA) media responses and materials and ensures accuracy and consistency of policy, style, and quality. Determines which items should be brought to the attention of the Assistant Secretary, the Executive Director for Public Affairs and senior VA officials.

- At the request of the Assistant Secretary for OPIA, conducts special or confidential studies of a complex nature which serve as a basis for recommending changes in program policies or operations.

Office of Field Operations (80E)

Overview

The Office of Field Operations provides Department-level public affairs support throughout the United States and Puerto Rico to ensure that VA's public and internal messages are provided to key stakeholders in the regions it supports. Field Operations provides public affairs advice and expertise to different VA organizations via six regional offices in Atlanta, Chicago, Dallas, Denver, Los Angeles, and New York.

Functions and Activities

- Facilitates interviews and responses to media queries in coordination with VACO Office of Media Relations and regional SMEs in their area of support.
- Distributes OPIA-generated news releases, media advisories, and internal field support packages for designated VA events to ensure synchronization of messages and effectiveness of information distributed to Veterans and key stakeholders.
- Provides onsite support to senior regional and national VA leadership for press interviews and public engagements, including support to SECVA.
- Plans and executes periodic training for VA facility public affairs personnel to ensure presence of a cadre of competent VA public affairs personnel nationwide.
- Provides senior advice and counsel to VA facilities and leaders throughout the country to ensure synchronization of VA's message.
- Plans and administers an annual national public affairs training academy, which trains more than 350 VA Public Affairs and Outreach Specialists.
- Provides periodic training for facility- and regional-level Public Affairs Officers that is tailored for the Department's Public Affairs Career Specialists (1035-series).

Office of Media Relations (80F)

Overview

The Office of Media Relations (OMR) serves as the Department's conduit with external news media. OMR plans and directs the Department's media engagement program. OMR helps plan issue-driven public communications campaigns; manages, and executes media events (press conferences, interviews, media roundtables, media support to major VA events, etc.); coordinates public affairs events with the Department's three Administrations and key program offices; drafts, distributes, and maintains news releases and fact sheets, communications plans, white papers, and similar products; and trains SMEs and Public Affairs Officers to develop their skills and improve their interactions with the news media.

Functions and Activities

- Drafts, coordinates, and implements media relations portions of communications plans.
- Composes, coordinates, and distributes news releases, talking points and related documents, such as statements articulating the Department's position and Questions and Answers (Q&A) for internal use.
- Identifies key news media personnel appropriate for an event, establish communications, and provide targeted written products to the news media.
- Provides After-Action Reports and lessons learned to continuously improve the Department's public affairs and media efforts and programs.

Coordinates with VA's three Administrations, Staff Offices, and major programs.

- Maintains a roster of VA public affairs professionals and SMEs.
- Supports public affairs training for VA offices and within the three Administrations.
- Establishes protocols and tools to ensure key offices are kept informed of printed articles, broadcast reports, and news queries/responses provided by OMR personnel.

Drafts, distributes and archives written products.

- Establishes protocols and relationships with program offices and provides accurate, timely, and comprehensive information to enable them to create quality written products.
- Identifies key news media outlets and appropriate personnel and provides them with VA's written products.
- Contracts with commercial SMEs to archive written products distribute news releases and assemble news clippings and other products used to brief SECVA and other senior VA leaders on media trends.

Authorities

VA Handbook 8500

Executive Director of Corporate Communications (002)

Overview

The Executive Director of Corporate Communication is the senior-ranking Federal employee within the Office of Public and Intergovernmental Affairs. As such, the Executive Director of Corporate Communications serves as the Assistant Secretary's senior advisor on all matters pertaining to personnel and operations, advertising, strategic communications, and is a key conduit with other OPIA Federal employees. The Director of Corporate Communications is also responsible for providing oversight, guidance and direction to the Office of National Veterans Outreach Office, the Office of Internal Communications and the Homeless Veterans Outreach and Strategic Communications Office.

Office of Internal Communications

Overview

The Office of Internal Communications is the lead OPIA office charged with improving and spreading internal communications across the enterprise. The goal of the office is to increase employee awareness of VA and VA employee initiatives, programs and achievements; and to increase employee engagement and productivity. By working collaboratively with OSVA, the three Administrations, and VACO staff offices, this office will highlight the great work VA personnel and VA facilities are doing for Veterans. Improving internal communications is a 2017 VA breakthrough priority, and is considered key to Improving the Veteran Experience and Improving the Employee Experience, two other VA breakthrough priorities.

Functions and Activities

- Functions as a liaison to the Office of the Secretary regarding Internal Communications strategy and independently considers a broad spectrum of factors when making recommendations on how to most effectively reach and inspire VA employees.
- Leads multiple enterprise-wide efforts to improve internal communications know-how, align internal communications strategy and increase synergy across VA. That includes:
 - Developing and conducting Internal Communications training for key stakeholders across VA
 - Leading the Internal Points of Contact advisory board with members from each VA administration and staff office.
 - Developing and disseminating Internal Communications toolkit to help key stakeholders become more efficient and effective in communicating with and inspiring excellence among VA employees.
- Manages and produces VA/OPIA-sponsored all-employee communications vehicles, including the MyVA News blog, *Vanguard* magazine and a MyVA News app for employees.
- Manages and produces internal communications campaigns and lead internal communications events.
- Develops internal communications materials and ensures accuracy and consistency of policy, style, and quality. Determines which items should be brought to the attention of the Assistant Secretary and senior VA officials.

National Veterans Outreach Office (002D)

Overview

The National Veterans Outreach Office coordinates integrated and strategic outreach program activities and related communications efforts throughout VA to increase Veterans' awareness and confidence in VA's health care, benefits, and services.

Functions and Activities

Coordinates outreach program activities.

- Produces a bi-annual outreach report for Congress and a separate outreach plan for internal VA use.
- Conducts outreach training for VA employees who serve in outreach duty assignments.
- Coordinates outreach program communications.
- Develops and maintains the Departmental advertising policy.
- Administers/supports the VA Advertising Oversight Board (VAAOB).
- Administers the Department's national advertising plans.
- Increases Veterans' awareness of and confidence in VA's health care, benefits, and services.
- Conducts pro-active, strategic outreach and engagement to military Servicemembers before they transition to the Veteran population.
- Develops partnerships with government, non-government, and private organizations to enhance the Department's outreach activities.

Coordinates communication planning activities.

- Develops annual planning calendar of outreach activities.
- Develops and distributes themes and messages to VA Administrations and Staff Offices.
- Coordinates communications and outreach efforts to promote common VA goals.
- Manages VAs' national observance and special events functions, such as Veterans Day and Memorial Day.
- Composes and publishes event products such as the Veterans Day Teachers Guide, distributed nationwide, and media products such as posters and Web-based information presentations.
- Maintains the Veterans Day Regional Site program.
- Oversees the Veterans Day National Committee ensuring Veterans Service Organizations are promptly informed of all Veterans Day and Memorial Day Observances.
- Coordinates and orchestrates the National Veterans Day Observance, at Arlington National Cemetery. Supports the Military District of Washington with planning for The Memorial Day Observance.

Authorities

38 U.S.C. § 6301-6308

Homeless Veterans Outreach and Strategic Communications Office (075D)

Overview

The Homeless Veterans Outreach and Strategic Communications Office is responsible for increasing awareness of VA resources from Veterans who are homeless and at risk of homelessness; developing collaborative relationships with organizations that can assist VA in filling gaps in the areas of employment, move-in essentials, and affordable housing for homeless Veterans; and coordinating with Federal, state, and local partner organizations to synchronize messaging about homeless Veterans' issues.

Functions and Activities

Increasing awareness of VA resources for homeless Veterans

- Leads the planning and execution of outreach and strategic communication activities, which includes the development and distribution outreach materials (brochures, posters, etc.), public service announcements (PSAs), and paid media advertisements (outdoor and online ads).
- Maintains the VA Homeless Programs internet and intranet websites.
- Develops content for internal and external social media platforms about VA homeless programs.
- Participates in local and national outreach events.
- Coordinates participation of senior VA leaders in the annual Point-in-Time (PIT) Count of homeless persons and other high profile events related to ending Veteran homelessness.
- Develops collaborative relationships with internal and external entities to fill identified gaps.
- Convenes meetings for VA subject matter experts to engage with local and national organizations that can help fill gaps in the areas of employment, affordable housing, and move-in essentials for Veterans who are homeless and at-risk of homelessness

Synchronizing messaging with partner agencies.

- Coordinates with Federal partners, as appropriate, to develop press releases for events and special projects and also creates communication products to include strategic communication plans, frequently asked questions (FAQ), talking points, and other tools necessary to support communication activities related to homeless issues.
- Coordinates with partner organizations to ensure information posted on their websites about VA homeless programs is accurate.

Providing Customer Service.

- Responds to requests for information about VA Homeless Programs from members of the general public.
- Directs Veterans who are homeless and at-risk of homelessness to the appropriate VA staff person or office for assistance.

Authorities

P.L. 102-590
 38 U.S.C. § 101
 38 U.S.C. § 7721

*Office of Intergovernmental Affairs***Overview**

The Office of the Deputy Assistant Secretary for Intergovernmental Affairs (IGA) is responsible for the oversight of two of the eight directorates and is the office of primary responsibility for all relations between VA and international, state, county, municipal, and tribal governments. IGA provides strategic advice, guidance, and information to the Office of the Secretary, Under Secretaries for Health, Benefits, and Memorial Affairs, and all other VA Staff Offices by fostering and enhancing government partnerships and acting as liaison between the White House, federal, state, local, tribal, insular, and international governments.

Functions and Activities

- Coordinates VA's relations with activities with state, county, municipal, tribal and International governments.
- Manages the Department's relations with States and coordinates VA's government relations with municipalities and counties.
- Coordinates and serves as liaison with the White House Office of Intergovernmental Affairs and with all Federal intergovernmental affairs counterparts.
- Manages VA's International Affairs program.
- Coordinates VA relations with tribal governments and facilitates implementation of VA Tribal Consultation Policy.

Office of State and Local Government**Overview**

Intergovernmental Relations is the VA office of primary responsibility for all relations between VA and international, state, county and municipal governments. States are important partners in the delivery of benefits and services to Veterans, and are attuned to the specific needs and issues of Veterans. As the designated VA liaison office to state and local governments, Intergovernmental Affairs collects and analyzes the capabilities, needs and concerns of governments to advise VA leadership and assist in policy development.

Functions and Activities

Serves as the VA office of primary responsibility for VA government relations with States:

- Builds and enhances government partnerships, and communications between VA and the offices of state governors, legislatures, state departments of Veterans affairs and other state agencies, and the National Guard Adjutant Generals.

- Maintains communication, enhances coordination, and assists in policy development with state-level Big 7 Intergovernmental Organizations – e.g. Council of State Governments (CSG), National Governors Association (NGA), and National Conference of State Legislatures (NCSL).
- Maintains communications, enhances coordination and conducts proactive outreach to DC based state offices and Federal relations representatives.
- Maintains communications and enhances coordination with State Directors of Veterans Affairs and the National Association of State Directors of Veterans Affairs (NASDVA) as specified in the VA/NASDVA Memorandum of Agreement (MOA) signed in 2016.
- Coordinates VA senior leader travel and meetings with Governors and State Directors of Veterans Affairs.
- Serves as the VA office of primary responsibility ensuring with all VHA/VBA/NCA program managers involved with administration and oversight over any program, grants and/or training involving state governments.

Coordinates and serves as liaison with the White House Office of Intergovernmental Affairs as well as all federal agency IGA counterparts.

Manages VA's International Affairs Program:

- Oversees all diplomatic outreach on behalf of SECVA, and VA senior officials and agencies.
- Coordinates visits by foreign dignitaries with SECVA and Under Secretaries.
- Coordinates with other Federal agencies, such as Department of State and DoD, on all foreign delegations' requests for meetings with national and local VA officials and locations.
- Coordinates SECVA and Deputy Secretary visits to foreign countries.
- Serves as the Department's lead program office for ministerial summit events.
- Coordinates the International Ministerial Summit and Senior International Forum, with all members of the FVEY alliance (US, Canada, Great Britain, New Zealand, Australia), where SECVA and his counterparts discuss a variety of issues common to Veterans of all participating countries. Forum is held approximately every 18 months and hosted by allies on a roving basis.

Authorities

EO 12372

EO 12160

Office of Tribal Government Relations

Overview

The Office of Tribal Government Relations (OTGR) supports VA's efforts to engage in positive government to government relationships with more than 500 tribal governments located in over 30 states. These

governmental relationships equip VA to effectively respond to the needs and priorities of Veterans living in Indian Country. Additionally, the agency is informed as it seeks to develop and expand existing partnerships that enhance Veterans and their families' access to services and benefits.

Functions and Activities

The OTGR ensures VA maintains an open and effective dialogue with American Indian and Alaska Native tribal governments.

- Coordinates VA relations, engagements and activities with tribal governments.
- Establishes partnerships and builds relationships with tribal governments, state governors, legislatures, and Cabinet-level Departments (including Departments of Education, Health and Human Services, Housing and Urban Development, Labor, and Interior).
- Conducts proactive outreach to tribal governments to establish and maintain open lines of communications and policy development.
- Coordinates travel and meetings between VA senior leaders and local elected and appointed tribal officials.
- Coordinates and advises VHA leadership involved with administration and implementation of the VA/Indian Health Services (IHS) MOU.
- Coordinates and advises VHA leadership involved with administration and implementation of the VA/IHS/Tribal Health Program Reimbursement Agreement Program.
- Coordinates and advises VBA leadership involved with administration and implementation of the Native American Direct Loan (NADL) Program on trust land.
- Coordinates with NCA leadership involved with administration and oversight of the Veterans Cemetery Grants Program on trust land.

Facilitates implementation of VA Tribal Consultation Policy:

- Serves as the policy advisor to the Secretary and agency leadership regarding implementation of the formal tribal consultation process necessary when policies and programs under consideration affect Veterans living in Indian Country.
- Develops, in collaboration with VA subject matter experts, issue papers, federal register notices and tribal consultation communications products.
- Facilitates access and direct communications between tribal leaders seeking to have their voices considered and heard by senior VA leadership and officials in order to have tribal government impact and perspectives considered in rule and policy making.

Authorities

EO 13175 VA Tribal Consultation Policy

Presidential Memorandum on Tribal Consultation – November 2009

VA Tribal Consultation Policy, February 4, 2011

VA Tribal Consultation Handbook and Directive 8603

Office of Congressional and Legislative Affairs

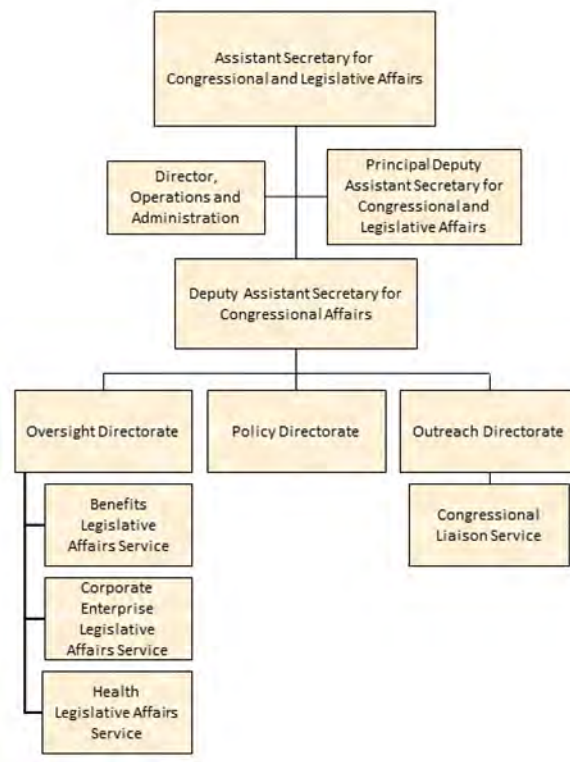


Figure 33 - Office of Congressional and Legislative Affairs Organization Chart

[Click here for the alternate representation of the chart](#)

Office of the Assistant Secretary for Congressional and Legislative Affairs

Mission

The mission of the Office of the Assistant Secretary for Congressional and Legislative Affairs is to improve the lives of Veterans and their families by advancing pro-Veteran legislation and maintaining responsive and effective communications with Congress.

Overview

OCLA coordinates the Department's activities with Congress. It is the Department's focal point for interactions and engagements with Members of Congress, authorization committees, and personal staff. Additionally, the Office is the Department's liaison with the Government Accountability Office (GAO).

Functions and Activities

Coordinates the Department of Veterans Affairs' relations and activities with Congress:

- Maintains responsive communications with Congress through briefings, hearings, correspondence, reports, site visits, requests for information, and other requested services from Members of Congress.

- Develops and executes the Department's legislative strategy and priorities and champions them before Congress.
- Leads the preparation and manages the Department's participation in congressional hearings , briefings, and accompanies VA personnel in meeting with Members of Congress, congressional committees, or staff.
- Coordinates the development of Veteran legislation, requests for views and technical support of the Department on pending or proposed legislation to benefit Veterans and improve the operations and efficiency of the Department.
- Manages the Department's 38 U.S.C. congressionally mandated reports process.
- Advises VA senior leadership, in coordination with program office and legal staff, on legislative matters.
- Provides congressional liaison support to Members of Congress and staff.
- Maintains liaison offices in Senate and House office buildings.
- Receives and processes member requests for assistance with constituent and policy inquiries.
- Receives, resolves, and responds to Veteran case inquiries from congressional offices.
- Serves as the Department's liaison with the GAO, monitoring GAO activities affecting VA and Veterans and notifies Department of all GAO engagements.
- Prepares responses to GAO draft and final reports, and ensures responses are provided to GAO in a timely manner and keeps VA leadership apprised of GAO recommended implementations.

Authorities

38 U.S.C. Part I, Chapter 3

Office of Congressional Affairs

Overview

The Office of the Deputy Assistant Secretary for Congressional Affairs (SES) is responsible for the oversight of three directorates: Policy, Oversight, and Outreach. This office focuses on policy and legislative issues in support of SECVA's legislative agenda and priorities. The office also is responsible for all congressional oversight matters and requests for information, and other related actions. This office is responsible for all outreach, including the congressional liaison offices and staff functions located on Capitol Hill. There are three director-level reports: Director of Policy, Director of Oversight, and Director of Outreach.

Functions and Activities

- Develops and executes the Office's Strategic Plan.
- Establishes goals, objectives, and priorities for the Policy, Oversight, and Outreach directorates.

- Supervises the Directors of Policy, Oversight, and Outreach directorates.
- Ensures effective and responsive communications with Congress.
- Provides advice and support to VA personnel in support of all interactions and engagements with Congress.
- Develops legislative priorities for the for the Policy directorate.

Authorities

38 U.S.C. Part I, Chapter 3

Oversight Directorate

Overview

The Office of the Director, Oversight, is responsible for all congressional oversight activities involving the Department's committees of jurisdiction and the Members of Congress who are on those committees. The office works with the Department's Administrations and Staff Offices in responding to congressional oversight matters and requests for information. There are three sub-director level reports: Director of Health, Director of Benefits, and Director of Corporate Enterprise. The office also services as the Department's liaison with the Government Accountability Office (GAO).

Functions and Activities

- Develops and executes the Office's Strategic Plan.
- Establishes goals, objectives, and priorities for the Health, Benefits, and Corporate Enterprise sub-directorates.
- Supervises the Directors of the Health, Benefits, and Corporate Enterprise sub-directorates.
- Ensures effective and responsive communications with Congress.
- Provides advice and support to VA personnel in support of all interactions and engagements with Congress.
- Plans and executes proactive briefings to Veteran-focused congressional committees.
- Encourages and facilitates relationship building with congressional and intradepartmental staff concerning Veterans health activities and initiatives.
- Obtains information from Congress to assist the Department in preparing for congressional engagements.
- Provides advice for, prepares, and accompanies VA personnel in meetings with congressional committees, staff, and certain Members of Congress.
- Responds to congressional committees or staff inquires and requests for information.

- Plans, supports, and accompanies Members of Congress and committee staff on approved travel.
- Prepares senior VA officials to testify before Congress and VA's review of hearing transcripts and VA's responses to hearing questions for the record.
- Provides liaison services between senior Department officials on VA programs, policies, and legislation affecting the Department and VA's message to Congressional committees identifying key points and risk areas.
- Services as the Department's liaison with GAO, monitoring GAO activities affecting VA and Veterans.
- Notifies Department of all GAO engagements and keeps VA leadership apprised of GAO recommendation implementations.
- Prepares responses to GAO draft and final reports, and ensures that responses to GAO are provided in a timely manner.

Authorities

38 U.S.C. Part I, Chapter 3

Outreach Directorate

Overview

The Office of the Director, Outreach, is responsible for managing the day-to-day outreach operations to all Members of Congress not associated with the Department's oversight committees. The Director is also responsible for overseeing liaison support to Members of Congress and congressional staff on all constituent casework requests.

Functions and Activities

- Develops and executes the Office's Strategic Plan.
- Ensures effective and responsive communications with Congress through responses to congressional inquiries, requests for information, executive correspondence and concurrence actions.
- Plans and executes proactive briefings to Members of Congress not on Veteran-focused congressional committees.
- Obtains information from Congress to assist the Department in preparing for congressional engagements.
- Provides advice for, prepares, and accompanies VA personnel in meetings with Members of Congress.
- Coordinates VA's message to Congress, identifying key points and risk areas.

- Provides congressional liaison support to Members of Congress and staff and provides administrative and operational support for Departmental activities on Capitol Hill.
- Manages the Congressional Liaison Service on Capitol Hill with offices in Senate and House office buildings.
- Receives, processes, and resolves Member requests for assistance with constituent and policy inquiries and responds to Veteran case inquiries from congressional staffers in Washington, DC, and district offices.
- Provides advanced notifications for SECVA, DEPSECVA, and COS travel.

Authorities

38 U.S.C. Part I, Chapter 3

Operations and Administration

Overview

The Office of the Director, Operations and Administration, is responsible for managing the day-to-day operations of OCLA's operations and administrative staff. The Director is responsible for overseeing the completion of assignments and ensuring execution of OCLA's office budget.

Functions and Activities

- Provides the Assistant Secretary with objective, independent assessments and recommendations regarding policy, initiatives, and program issues requiring the Assistant Secretary's decision and action.
- Provides readiness support for the front office management and operational continuity throughout the organization.
- Provides assessment, recommendations, and assistance to the Assistant Secretary, Principal Deputy Assistant Secretary for Congressional Affairs, and Deputy Assistant Secretary for Congressional and Legislative Affairs in all phases of Veterans legislation and daily activities.
- Performs and oversees special studies and projects for the Assistant Secretary.
- Oversees completion of assignments from OSVA and other internal VA offices.
- Oversees day-to-day activities of administrative staff assigned to OCLA.
- Develops and manages the office budget.

Authorities

38 U.S.C. Part I Chapter 3

Office of Veterans Experience

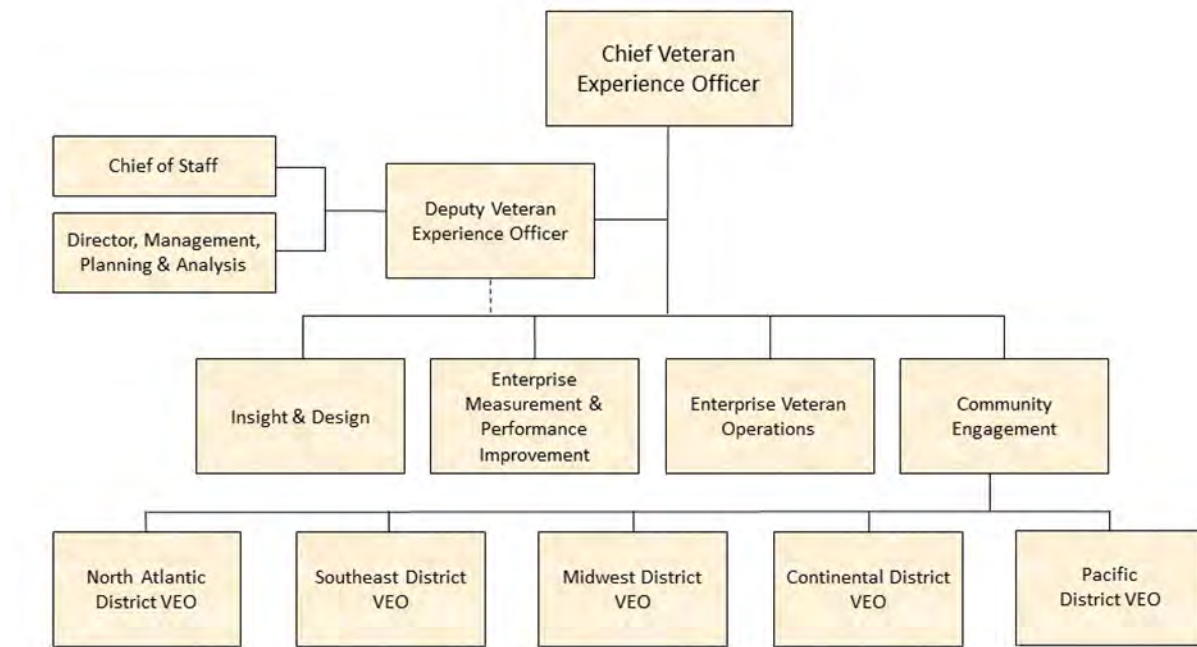


Figure 34 - Office of Veterans Experience Organization Chart

[Click here for the alternate representation of the chart](#)

Mission

Team with our colleagues to align what we do at the Department of Veterans Affairs (VA) with the needs and expectations of those we serve.

Office of the Chief Veterans Experience Officer

Overview

The Office of Veterans Experience (OVE) is headed by the Chief Veterans Experience Officer and immediately supported by the Deputy Chief Veterans Experience Officer (Deputy Chief) and the Chief of Staff. It was created by the Secretary of Veterans Affairs, not by legislative authority. This Office, in close coordination with VA's Administrations and Staff Offices, is creating new capabilities to transform the Department into the most customer-centric agency in the federal government.

The Deputy Chief serves as the second-in-command and OVE's chief operating officer. In this capacity, the Deputy Chief directs the policy and operations, provides broad direction, and ensures coordinated action and conformance with its mission.

Functions and Activities (Chief and Deputy Chief)

- Represents the voice and perspective of Veterans and their families in departmental governance.

- Articulates the needs of the Department’s customers; ensures VA resources are allocated on the basis of the best return to meet those needs.
- Integrates and coordinates VA resources across physical and virtual interactions with Veterans to ensure delivery of excellent healthcare and benefit experiences.
- Designs, implements, and manages a portfolio of enterprise level, customer-centric projects that will simplify customer’s interactions with VA and help Veterans understand and access care and services provided by VA and their local communities.
- Supports VA “mission owners” – those leaders responsible for delivering, day-in and day-out VA care services, and products to Veterans – in meeting their goal for improving customer experience.
- Oversees VEO’s corporate communications processes and efforts to strengthen VA’s relationship with Veterans, Servicemembers, and their families.

Office of the VEO Chief of Staff

Overview

The Chief of Staff (COS) works closely with the Chief Veterans Experience Officer and the Deputy Chief to manage day-to-day operations. In this capacity, the COS serves as the central coordination point for all high-level negotiations involving the establishment or implementation of VEO policies, procedures, management, and project management activities. Additionally, the COS provides executive leadership to the following services and offices: Insight and Design; Enterprise Measurement and Performance Improvement, Community Engagement, and Enterprise Veteran Operations.

Functions and Activities

- Works closely with the Chief Veterans Experience Officer and the Deputy Chief to manage VEO’s day-to-day operations.
- Ensures that VEO’s communications are clear, concise, accurate, and aligned with the Department’s positions and strategic direction.
- Ensures that VEO works closely and effectively with our partners throughout the Department.

Management, Planning and Analysis

Overview

The Management, Planning, and Analysis (MP&A) Directorate is responsible for providing consistent operating practices between the headquarters and community engagement teams related to workforce planning, financial management, budget administration, resource planning, business oversight activities, acquisition and tracking of OVE’s performance measures.

Functions and Activities

- Drafts and disseminates policy and operating procedures

- Develops programming and budgetary requirements for current and future years
- Coordinates with the Central Office Human Resources Teams to address matters related to staffing, employee relations, and labor relations
- Gathers acquisition requirements, assists with drafting associated documentation, and tracks status throughout the acquisition lifecycle
- Provides logistical support, as well as any other operational needs to VE personnel in support of the organizational mission.

Insight and Design

Overview

The Insight and Design Office creates a consistent shared understanding of who VA's customers are, what they want, need and how they perceive their interactions with the Department. It spans the complex system of people, products, interfaces, services and physical spaces that VA's customer encounter in settings such as medical facilities, over the phone, or through digital media (e.g., websites, mobile applications and kiosks). Additionally, this Office undertakes key service design projects in service of seamless end-to-end customer experience.

Functions and Activities

- Gather and analyze qualitative field data to determine what VA's customers want and need and then map the key moments that matter to them.
- Utilize the human-centered design process to design experiences across online and offline touch points that matter to VA's customers, employees, and partners via the utilization of iterative research, idea generation, prototyping, launch and evaluation.
- Provide communication, visual, interaction, and service design that's integrated by various teams within VA.
- Rollout human-centered design through VA to support the Department's transformation toward becoming customer-centric.

Enterprise Measurement and Performance Improvement

Overview

The future of customer experience (CX) at VA is an integrated "outside-in" view of the customers' end-to-end journeys by which the Department is held accountable to its customers. In order to achieve this vision, OVE listens to the agency's customers and ties their experiences back to operational drivers. By understanding VA's performance through the lens of our customers, OVE can prioritize improvements that enhance Veterans experience with VA.

Functions and Activities

- Establish and report on agency-wide CX measures.
- Enhance customer experience feedback around moments that matter to Veterans.

- Improve employee access to integrated actionable customer experience data insights.

Enterprise Veteran Operations

Overview

The Enterprise Veterans Operations Office, in partnership with other VA offices, ensures services offered via web self-service and contact centers are designed and implemented based on customer insights, and are supported by authoritative customer information. The Office partners with VA's Office of Information and Technology to deliver high touch, technology-enabled customer service capabilities throughout the enterprise thus enabling Veterans and others to access information, benefits and services anywhere, anytime.

Functions and Activities

- Ensures a more Veteran-centric VA by integrating and delivering via all customer facing services and channels.
- Builds, deploys and maintains enterprise-applications, tools and infrastructure for the delivery of Veteran Experience products, services and information (e.g., Vets.gov, customer experience management system (VOICE) enterprise interactive voice response or IVR).
- Provides business process management and re-engineering, business requirements development and management, user acceptance testing, deployment, and training of enterprise wide applications to meet clients' needs.

Community Engagement

Overview

OVE's Community Engagement team consists of five District Veterans Experience Officers (DVEO) and a headquarters management and support function. The DVEOs are located in each of the five VA Districts (e.g., North Atlantic, Southeast, Midwest, Continental, and Pacific) and their respective staffs are located across the country in geographic hubs throughout each District. The DVEOs and his/her staff represent the voice of the Veterans in VA and community activities. Their primary responsibility is the local implementation of VEO initiatives designed to improve the veterans' experience and rebuild trust in the VA.

VEO initiatives are developed based on insight obtained through formal and informal channels. DVEO staff share knowledge obtained in local settings with VEO headquarters to improve ongoing initiatives and to help shape future initiatives. In addition, the Community Engagement team delivers the MyVA Veteran Experience through enterprise level navigation, advocacy, education, community engagement and outreach.

Functions and Activities

DVEO staff undertake the following activities:

- Implements OVE initiatives in the Districts.

- Collects and provides feedback on VA initiatives and programs and provide that information to Insight and Design in support of continuous improvement efforts.
- Analyzes available data to identify opportunities for improvement.
- Shares best practices and lessons learned within and across Districts.
- Builds collaborative networks within VA and among state directors, community strategic partners, and other stakeholders to improve outcomes and share information to maximize the effective delivery of services across all regions.

The Community Engagement team executes the following activities:

- Assists DVEO staff by providing tools and guidance to support their mission.
- Supports VEO by collecting and analyzing DVEO information at the national level and identifying trends and tracking resources. Support a national network of Community Engagement Veteran Boards (CVEB) that integrate VA with the broader set of public and private resources available to Veterans in their communities, ensuring Veterans get the support they need and have a forum for their voices to be heard.

Office of Enterprise Support Services

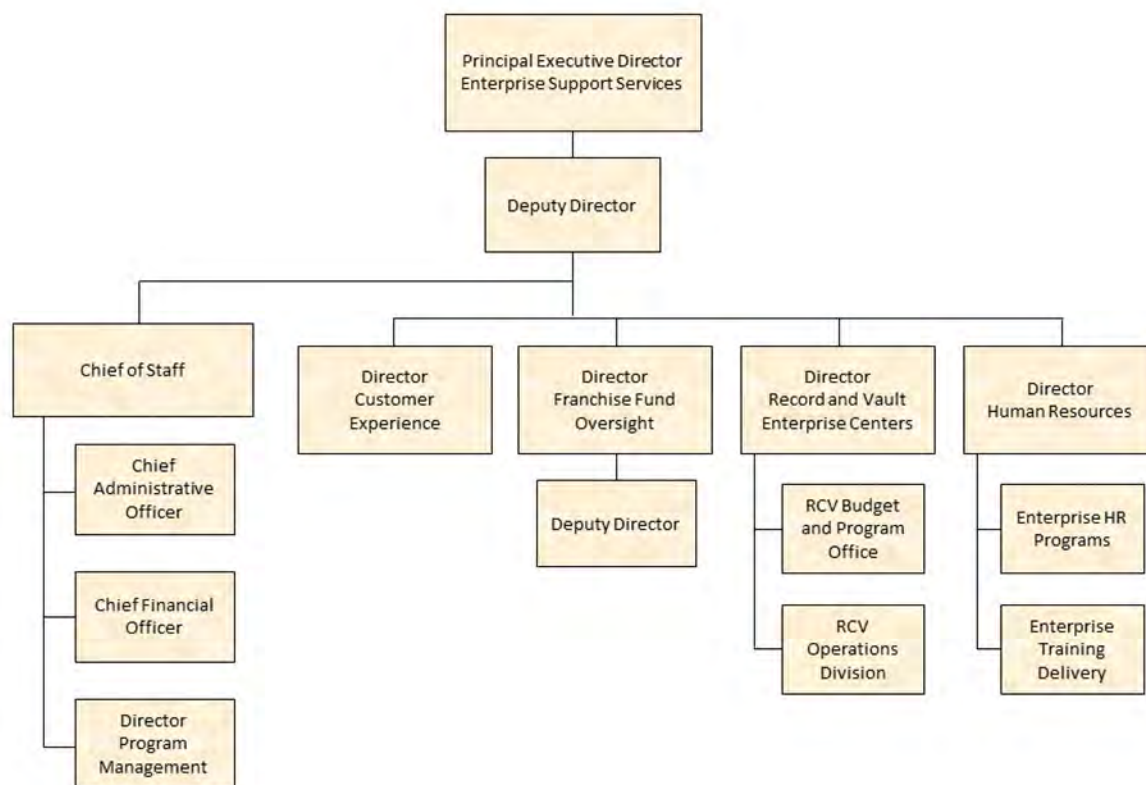


Figure 35 - Office of Enterprise Support Services Organization Chart

[Click here for the alternate representation of the chart](#)

Mission

To deliver best-in-class services and capabilities to VA's organizations and functions that enable them to focus on delivering world-class health care, benefits, and memorial services to Veterans and their eligible family members.

Office of the Principal Executive Director, Enterprise Support Services

Overview

The Office of Enterprise Support Services (OESS) is led by the Principal Executive Director for Enterprise Support Services and is immediately supported by the Deputy Director for Enterprise Support Services and the OESS Chief of Staff. The Office for Enterprise Support Services was created by the Deputy Secretary of Veterans Affairs and approved by the VA Support Services Governance Board (SSGB). The Principal Executive Director for Enterprise Support Services reports directly to the Deputy Secretary of Veterans Affairs and is responsive to guidance and direction from the VA Support Services Governance Board (SSGB) where the Deputy Secretary serves as Chair. At the direction of the SSGB, the Principal Executive Director for the Office of Enterprise Support Services also serves as the Director of the VA Franchise Fund.

The VA Franchise Fund was authorized by the Government Management and Reform Act of 1994, P.L. 103-356. Established in 1997, common VA administrative support services were financed on a fee-for-service

basis rather than through VA's General Administration appropriation. Permanent status was conferred upon the VA Franchise Fund by P.L. 109-114.

The Office of Enterprise Support Services is completely funded through the VA Franchise Fund, not appropriated funds, and serves the VA Administrations and Staff Offices through transparent fee-for-service programs and activities designed to focus on customer service, improve the consistency and quality of VA services, and deliver lower costs. This Office, in direct support of customers in VA's Administrations and Staff Offices, creates new enterprise capabilities and innovation to transform the Department's mission support services to deliver reliable, consistent, cost-effective support services across the VA enterprise for the following: human resource services; debt management; financial and accounting services; payroll processing; travel and payment processing; electronic commerce/electronic data interchange; background investigations and adjudications for employees and contractors; special training for VA police officers; and records storage, protection, and management services.

The Deputy Director serves as the second-in-command and as OESS's chief operating officer. In this capacity, the Deputy Director directs policy and operations, provides broad direction, and ensures coordinated action and conformance with its mission and in partnership with enterprise process improvement and VA transformation efforts.

Functions and Activities (Director and Deputy Director)

- Represents the Department of Veterans Affairs as the single voice of VA shared services to the Federal Government Shared Service Community aligned with the President's Cross-Agency Priority Goal for shared services and in accordance with Office of Management and Budget (OMB) policies and processes. Provides a single VA point of contact to the Unified Shared Service Management (USSM) Office of OMB and the Government Services Agency (GSA).
- Defines the policies, strategies, programs, projects, and activities needed to accomplish the goals, objectives, and outcomes for exceptional support services across the Department of Veterans Affairs.
- In direct support of VA lines of business (VA Administrations and Staff Offices), delivers better services at lower costs, leveraging existing and future Franchise Fund Enterprise Service Centers (ESC) and other VA support services, as measured by agreed-upon Service Level Agreements (SLA) and Key Performance Indicators (KPI).
- Hosts monthly board meetings of the VA Support Services Governance Board (SSGB) and receives direction and guidance from the SSGB. Provides data-driven recommendations for decision, enforces enterprise implementation and execution of decisions, and monitors and updates the SSGB on performance management dashboards and key performance metrics for the Enterprise Service Centers as well as VA functional enterprise shared services for IT, HR, finance, and contracting. Informs the SSGB on the status and compliance of the VA Franchise Fund with statutes, regulations, policies, and fiduciary requirements in coordination with the VA Chief Financial Officer (CFO) and Office of Management (OM).
- Integrates and synchronizes VA enterprise transactional (day-to-day) work performed by the VA Enterprise Service Centers (ESC), VA Administration or Staff Offices for IT, HR, finance, contracting, leasing, enterprise training, law enforcement, and background investigations.

- Designs, implements and manages a portfolio of enterprise-level, customer-centric projects that focus on VA business line customer requirements and delivers reliable, consistent, efficient and cost-effective mission support services. Delivers continuous process improvement through Lean and Lean Six Sigma principles across VA Enterprise Service Centers. Leverages best practices across the federal government and industry to significantly improve enterprise support services.
- Aligns SES performance plans for the Principal Executive Director and Deputy Director with customer satisfaction, quality, cost and other agreed-upon performance metrics from VA customers.
- Innovates and builds organizational capacity within OESS to take on additional enterprise transactional work by defining the work, identifying the people associated with work, and resourcing OESS to perform the work. Aligns performance metrics with service level agreements from VA lines of business and customers.
- Oversees OESS's corporate communications processes and efforts to strengthen VA's relationships with Veterans, Servicemembers, and their families through delivering better services to VA lines of business and VA employees at lower cost, enabling them to focus on delivering better Veteran outcomes.

Office of the OESS Chief of Staff

Overview

The Chief of Staff (COS) works closely with the Principal Executive Director and the Deputy Director, OESS to manage day-to-day operations, programs, contractual support, and OESS outcomes. In this capacity, the COS serves as the central coordination point for all high-level negotiations involving the establishment or implementation of OESS policies, procedures, program management, project management, and contractual support activities. Additionally, the COS provides executive leadership to the following services and offices: Chief Administration Officer, Chief Financial Officer, and Chief Program Management Office.

Functions and Activities

- Accountable to the Principal Executive Director and Deputy Director for Enterprise Support Services to manage OESS's day-to-day operations.
- Drafts and disseminates VA support services policy, operating principals, operating model, and standard operating procedures. Ensures continuous process improvement and Lean/Lean Six Sigma principals for VA support services and Enterprise Service Centers.
- Develops programming and budgetary requirements for current and future years. Supports the Director OESS to ensure compliance with fiscal regulations and policies related to the VA Franchise Fund.
- Supports the VA Support Services Governance Board (SSGB) with data-driven, decision-quality information, data analytics and performance management.

- Develops and implements the VA Program Management Plan (PMP) for Support Services in accordance with Program Management Body of Knowledge (PMBOK) Principals. Delivers regular program management reviews to ensure OEES is meeting cost, schedule and performance metrics focused on the delivery of mission support services aligned with customer expectations and Service Level Agreements.
- Ensures that OEES's communications are clear, concise, accurate, and aligned with the Department's vision and strategic direction. Coordinates communications strategies with the MyVA Task Force, the Office of Enterprise Integration, and the Office of Intergovernmental and Public Affairs.
- Ensures that OEES works closely and effectively with our partners throughout the Department. Ensures engagement with national stakeholders including Congress, Veterans Service Organizations, National and local Labor Unions, other Federal agencies, media, and Veterans.
- Ensures that OEES works closely and is aligned in policy and process with OMB and the Office of Unified Shared Service Management (USSM).

Customer Experience and Customer Experience Directorate

Overview

The Customer Experience Directorate is responsible for providing exceptional customer service to the VA lines of business including the VA Administrations and Staff Offices. The Directorate is accountable to deliver on customer service expectations aligned with the customer journey map and Service Level Agreements (SLA's).

Functions and Activities

- Directly supports the VA Administrations and the Board of Veterans Appeals (BVA) with customer-centric delivery of mission support services aligned with Service Level Agreements (SLA) and Key Performance Indicators (KPI). Has a deep understanding of the VA lines of business for health care, benefits, appeals, and memorial affairs and their requirements for mission support services for IT, HR, contracting, leasing, finance, training, law enforcement, and background investigations.
- Gathers acquisition requirements from the VA lines of business, assists with drafting required artifacts and documents for an acquisition-ready package, and tracks status throughout the acquisition lifecycle for mission support services.
- Provides expert advice, consultation, and data-driven recommendations to improve customer service for all VA mission support services as well as for existing and future VA Enterprise Service Centers (ESC).

Franchise Fund Oversight Office (FFOO)

Overview

The VA Franchise Fund was established under the authority of the Government Management Reform Act of 1994 and the VA and Housing and Urban Development and Independent Agencies Appropriations Act of 1997. VA was selected by the Office of Management and Budget (OMB) in 1996 as one of six Executive

branch agencies to establish a franchise fund pilot program. Created as a revolving fund, the VA Franchise Fund began providing common administrative support services to VA and other government agencies in 1997 on a fee-for-service basis. In 2006, under the Military Quality of Life and Veterans Affairs Appropriations Act, P.L. 109-114, permanent status was conferred upon the VA Franchise Fund. The mission of the VA Franchise Fund is to be the provider of choice of common administrative support services for VA and other government agency customers, enabling them to best meet their primary missions.

The VA Franchise Fund is comprised of an administrative office (Franchise Fund Oversight Office) and seven self-supporting lines of business (Enterprise Service Centers, or ESC). The current VA ESCs include the following: the Financial segment (under the oversight of the Office of Management) including the Financial Services Center (FSC) in Austin, Texas, and the Debt Management Center (DMC) in St. Paul, Minnesota; the Personnel Security and Law Enforcement segment (under the oversight of the Office of Operations, Security, and Preparedness) including the Security and Investigations Center (SIC) and the Law Enforcement Training Center (LETC), both in North Little Rock, Arkansas; the Information Technology segment, including the Enterprise Operations (EO) Center in Austin, TX (under the oversight of the Office of Information and Technology); and the Records Center and Vault in Neosho, Missouri (under the oversight of the Office of Enterprise Support Services).

A seventh Enterprise Service Center will be stood up in FY 2017: the Human Resources Enterprise Center (HREC) in Washington, DC, under the oversight of the Office of Enterprise Support Services. It will be the first new Enterprise Services Center since 1994. The directors of the individual Enterprise Service Centers and their staffs are responsible for customer satisfaction, support to the VA lines of business, Enterprise Service Center business planning and development, staffing, and execution of day-to-day business activities consistent with their annual business plans. The VA Franchise Fund Oversight Office (FFOO) and its Director are accountable for enterprise best practices, standard business plan development, fiduciary audits, and financial stability of the VA Franchise Fund in accordance with statutes, regulations, and policies.

Functions and Activities

- Provide policy, process, guidance, and direction to the seven Enterprise Service Centers (ESC) and any future ESCs for delivering exceptional customer service, high quality, reliable, and consistent mission support services at lower costs.
- Draft, brief to the Support Services Governance Board (SSGB), and implement new policies for the VA Franchise Fund, aligned with OMB policy memoranda and Unified Shared Service Management (USSM) emerging policies and processes. Be accountable to deliver enterprise-wide performance dashboard and transparent performance metrics for enterprise mission support services performed by VA Enterprise Service Centers.
- In coordination with the Office of Management (OM) and the Office of Finance (OF), ensure clean audit results for the VA Franchise Fund. Take appropriate actions related to all OIG and GAO findings on the VA Franchise Fund to ensure compliance with fiduciary requirements and Federal Government best practices.
- In coordination with the seven Enterprise Service Centers and their respective operational headquarters, ensure enterprise-wide performance management through dashboards, leading

indicators, and Key Performance Indicators aligned with customer-focused Service Level Agreements.

Records Center and Vault (RCV)

Overview

Transferred from the Office of Information and Technology (OI&T) to the Support Services Excellence (SSE) initiative in April 2016, the Records Center and Vault (RCV) provides exceptional customer service for long-term storage of Veterans' records and essential VA corporate and business line documents. RCV is certified by the National Archives and Records Administration (NARA) to operate as an agency records center. General, vital, and unscheduled records pending litigation freezes are safely and efficiently stored in paper or film format. Services include records storage and records management at cost-effective price points. Future services include digital records scanning and storage, microfiche scanning, and contract management.

Functions and Activities

- Provide exceptional customer service at high quality and low cost aligned with Service Level Agreements. Deliver on Key Performance Indicators associated with customer SLAs. Drive lower costs through efficiencies in process (Lean and Lean Six Sigma), innovation, and implementation of new technologies.
- Support the VA Franchise Fund Oversight Office to provide key performance metrics for customer service, quality and cost. Provide monthly reports through dashboards to the SSGB on RCV performance.
- Improve customer service through quarterly customer meetings. Develop transactional customer performance survey capture mechanisms to measure performance in near real time. Adjust processes and procedures to capitalize on performance feedback and customer service metrics.
- Develop future capabilities to standardize, consolidate, and optimize enterprise VA records management processes, people, and technologies.

Human Resources Enterprise Center (HREC)

Overview

The Human Resources Enterprise Center (HREC) is first new VA Enterprise Services Center to stand up since 1994. On August 18, 2016, the Secretary of Veterans Affairs made the decision to stand up a new Enterprise Services Center to deliver selected enterprise Human Resource services under the Office of Enterprise Support Services. The HREC will deliver enterprise training and HR programs in support of the MyVA vision for support services excellence. People, process, and technologies will transfer from the Office of Human Resource and Administration (OHRA) to the Office of Enterprise Support Services (OESS) in January 2017 to deliver exceptional customer service for enterprise training and HR programs aligned with Service Level Agreements for performance and cost. The HREC will expand capabilities as necessary to take on additional HR transactional work such as staffing, retirement benefits, and other HR services as the Support Services Governance Board (SSGB) approves and directs.

Functions and Activities

- Deliver enterprise HR services at exceptional levels of customer service, high quality, and lower cost.
- In coordination with the Chief Human Capital Officer (serving as the VA Chief Learning Officer (CLO)), provide exceptional HR enterprise training services including people, process, and technologies. Align VA learning management systems with OMB policies to utilize Federal shared service providers for e-learning solutions. Define transactional costs for e-learning in order to develop and apply activity based costing models for enterprise training service delivery models.
- Deliver enterprise HR program support for White House and VA intern programs, employee notification, safety, and emergency preparedness services with high levels of customer service, quality, and lower costs.
- Develop capacity to deliver future HR enterprise services such as staffing, Position Description (PD) classification, retirements benefits, and other HR transactional services. In coordination with VA Administrations and Staff Offices, develop requirements for enterprise HR services that deliver return on investment for VA lines of business.

Appendix A: List of Acronyms

LIST OF ACRONYMS

Term	Definition
A/E	Architecture and Engineering
A-19	OMB Legislative Coordination and Clearance Circular
AAD	Asset Accountability Division
AAR	After Action Report
AARP	American Association of Retired Persons
ABS	Acquisition Business Service
ACA	Affordable Care Act
ACMO	Advisory Committee Management Office
ACMV	Advisory Committee on Minority Veterans
ACR	American College of Radiology
ACUP	VHA Animal Care and Use Programs
ACWV	Advisory Committee on Women Veterans
ADHC	Adult Day Health Care
ADR	Alternative Dispute Resolution
ADUSH	Assistant Deputy Under Secretary for Health
ADUSH/AO	Assistant Deputy Under Secretary for Health for Administrative Operations
ADUSH/CO	Assistant Deputy Under Secretary for Health for Clinical Operations
ADUSH/OM	Assistant Deputy Under Secretary for Health for Operations and Management
AGC	Assistant General Counsel
AI/AN	American Indian/Alaska Native
AIS	Office of Acquisition Internship School
ALAC	Administrative and Loan Accounting Center
ALS	Amyotrophic Lateral Sclerosis
AMC	Appeals Management Center
AMSUS	Society of Federal Health Agencies
AN-98	Home Health Services Program
AO	OIT CIO Action Officer (AO) Branch
APG	Agency Priority Goal required by the Government Performance and Results Act Modernization Act of 2010
APRN	VHA Advanced Practice Registered Nurses
AR	The Health Executive Council's Annual Report to Congress on the VA/DoD JSP.
ARC	VHA Allocation Resource Center
ARCH	Project Access Received Closer to Home
ASD	Architecture, Strategy and Design
ATR	Active threat response
AWPA	Alternative Workplace Arrangement/Agreement (telework)
BAS	Benefits Assistance Service
BCI	Brain-computer interface
BEC	Benefits Executive Council
BFAD	Benefits Financial Assurance Division
BIM	Building Information Modeling
BIO	Business Intelligence Office
BIRLS	Beneficiary Identification and Records Locator Subsystem database
BOC	Budget Object Codes
BOP	IT Budget Operating Plan

BOSS	Burial Operations Support System
BPR	Business Process Reengineering
BPRO	Business Process Reengineering Office
BPS	Benefits Product Support
BSM	Business Systems Management Office
BT	Beneficiary Travel program
BTT	IT Budget Tracking Tool
BVA	Board of Veterans' Appeals
C&P	Compensation and Pension
CAA	Clean Air Act of 1970, as amended
CAATS	Centralized Administrative Accounting Transaction System
C-ADHC	Community Adult Day Health Care
CAI	Center for Acquisition Innovation
CAI	Capital Asset Inventory
CAO	Chief Acquisition Officer
CAP	Corrective Action Plans
CARF	Commission on Accreditation of Rehabilitation Facilities
CART	Clinical Assessment Reporting and Tracking
CBI	VHA Office of Compliance and Business Integrity
CBO	VHA Chief Business Office
CBOPC	VHA Chief Business Office Purchased Care
CBSO	Clinical Business System Office
CDC	Centers for Disease Control and Prevention
CDI	Customer Data Information
CDW	Corporate Data Warehouse
CEDB	Corporate Employee Development Board
CERCLA	Comprehensive Environmental Response, Compensation, and Liability Act of 1980
CFBNP	Center for Faith-based and Neighborhood Partnerships
CFM	Construction, Facilities and Management
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CGE	Concur Government Edition
CHAMPVA	Civilian Health and Medical Program of VA
CHCO	Chief Human Capital Officer
CHGB	Connected Health Governance Board
CHO	Connected Health Office
CHTW	Coming Home to Work Program
CIA	Central Intelligence Agency
CIO	Chief Information Officer
CKMS	Congressional Knowledge Management System
CLC	Community Living Center
CLP	Continuous Learning Points
CM&SWS	Care Management and Social Work Services
CMOP	VA Consolidated Mail Outpatient Pharmacy
CMS	Centers for Medicare and Medicaid Services
CMV	Center for Minority Veterans
CNH	Community Nursing Homes
CNO	VHA Chief Nursing Officer

CNS	Clinical Nurse Specialist
CoE	Center of Excellence
COHRS	Central Office Human Resources Service
COMSEC	Communications Security
COOP	Continuity of Operations Plan
COPD	Chronic Obstructive Pulmonary Disease
CORK	Conference Oversight and Reporting Knowledgebase
COS	Chief of Staff
COSVA	Chief of Staff of Veterans Affairs
COTR	Contracting Officer Technical Representative
COTS	Claim scrubbing software for proper payment.
CP	Compensation and Pension
CPAC	Consolidated Patient Account Centers
CPES	Claims Processing and Eligibility System
CPG	VHA Evidence-Based Clinical Practice Guidelines Program
CPPO	Clinical Pharmacy Program Office
CREW	VA Civility, Respect and Engagement in the Workforce initiative
CRISP	Continuous Readiness in Information Security Program
CRNA	Certified Registered Nurse Anesthetists
CSEMO	Corporate Senior Executive Management Office
CSI	Clinical Specific Initiatives
CSM	Central Business Office (CBO) Systems Management
CSO	Caregiver Support Office
CSR	Continuous Readiness Program
CTRO	Corporate Travel Management and Reporting Office
CWA	Clean Water Act of 1977
CWINRS	An automated case management system supporting the VRE program.
CWV	Center for Women Veterans
CWVW	Children of Women Vietnam Veterans Health Care Program
DAEO	Designated Agency Ethics Official
DAIC	Department of Audits and Internal Controls
DAS	Deputy Assistant Secretary
DASHO	Designated Agency Safety and Health Office
DBQ	Disability Benefits Questionnaire
DCDM	Document Control and Data Management Department
DCID	Director of Central Intelligence Directives
DCIO	Deputy Chief Information Officer
DCSD	Data Center Support Division
DEERS	DoD's Defense Enrollment Eligibility Reporting System
DEMOB	Interagency Health Affairs Demobilization Program
DEPSECVA	Deputy Secretary of Veterans Affairs
DERG	Devolution Emergency Relocation Group
DFAR	Defense Federal Acquisition Regulations
DFAS	Defense Finance and Accounting Service
DGA	Data Governance and Analysis
DHS	Department of Homeland Security
DIC	Dependency Indemnity Compensation
DM&EEO	VBA Office of Diversity Management and Equal Employment Opportunity

DMA	VHA Disability and Medical Assessment Program Office
DMC	Debt Management Center
DOD	Department of Defense
DOD HA	Department of Defense Health Affairs
DOD/VAIPO	DoD/VA Interagency Program Office
DOT	Department of Transportation
DQS	Data Quality Service
DSS	Decision Support System
DUSHOM	Deputy Under Secretary for Health for Operations and Management.
DUSHPS	Deputy Under Secretary for Health Policy and Services
DV/IPV	VHA Domestic Violence and Intimate Partner Violence program
DVAAP	Disabled Veterans Affirmative Action Program
DVC	Deputy Vice Chairman
E2ERM	VA End-to-End Requirements Methodology
EA	Enterprise Architecture
EAC	Enterprise Architecture Council
EAP	Employee Assistance Program
EBP	Evidence-Based Practice
EBPWG	VHA Evidence-Based Practice Working Group
ECF	Executive Career Field
eCMS	VA's Electronic Contract Management System
ECOE	Epilepsy Centers of Excellence
ECST	Enterprise Cybersecurity Strategy Team
EDI	Electronic Data Interchange
EDVOC	Educational Vocational Fund.
EDW	Enterprise Data Warehouse
EEO	Equal Employment Opportunity
EEOC	Equal Employment Opportunity Commission
EES	Employee Education System
EEV	Eligibility, Enrollment, and Verification (EEV) Departments
EHCPM	VA Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
EO	Executive Order
EO	Presidential Executive Order
EO	Enterprise Operations
EOB	Emblems of Belief
EPCRA	Emergency Planning and Community Right-to-Know Act of 1986
ePMO	Enterprise Program Management Office
EPRP	External Peer Review Program
EPS	Environmental Programs Service
EPSS	VR&E Electronic Performance Support System
ERG	Emergency Relocation Group
ERM	VHA Office of Enterprise Risk Management
ESC	Executive Synchronization Committee
ESE	Enterprise Systems Engineering
ESF	Emergency Support Functions
ESP	Evidence-based Synthesis Program

ETS1	E-Gov Travel Service 1
ETS2	E-Gov Travel Service 2
EUL	Enhanced Use Lease Program
FA	Field Assistance Unit
FAC	Facility Acquisition Center
FAC-C	Federal Acquisition Certification -- Contracting
FAC-COR	Federal Acquisition Certification -- Contracting Officer's Representative
FAC-P/PM	Federal Acquisition Certification -- Program and Project Management
FAR	Federal Acquisition Regulation
FAR/VAAR	Federal Acquisition Regulation/VA Acquisition Regulation
FARA	Federal Acquisition Reform Act of 1996 (
FAS	Financial Accounting Service
FASA	Federal Acquisition Streamlining Act of 1995
FBCS	Fee Basis Claims Systems
FBO	VHA Finance and Business Operations
FCA	Facilities Condition Assessment
FCEA	Food, Conservation and Energy Act of 2008
FCMT	Federal Case Management Tool
FedRAMP	Federal Risk and Authorization Management Program
FEMA	Federal Emergency Management Agency
FEORP	Federal Equal Opportunity Recruitment Programs
FFO	Franchise Fund Oversight Office
FFRDC	Federally Funded Research and Development Center
FHA	Federal Health Architecture
FHS	Financial Healthcare Service
FHTP	Federal Healthcare Training Partnership, a partnership of federal agencies that have a clinical training mission.
FIPS	Federal Information Processing Standard
FISMA	Federal Information Security Management Act
FIT	Financial Innovation and Transformation initiative
FLRA	Federal Labor Relations Authority
FMFIA	Federal Managers Financial Integrity Act
FMP	Foreign Medical Program
FMR	Federal Management Regulation
FMS	Financial Management System
FMS	VA legacy financial system
FNOD	First Notice of Death
FOH	Federal Occupational Health
FOIA	Freedom of Information Act
FOM	VA Functional Organization Manual
FOS	Financial Operations Service
FPIAR	Financial Process Improvement and Audit Readiness
FPMR	Federal Property Management Regulations
FPMS	IT Financial Planning and Management Service
FRC	Federal Recovery Coordinators
FRCP	Federal Recovery Coordination Program
FRPC	Federal Real Property Council
FSC	Financial Services Center

FSIP	Federal Service Impasses Panel
FSRIA	Farm Security and Rural Investment act of 2002
FSS	Field Security Service
FTF	Freeze the Footprint
FtP PACT	Fix the Phones Patient Aligned Care Teams
GAO	Government Accountability Office
GDR	Ground Defense and Recovery techniques
GEAR	Goals Engagement Accountability Results program
GEC	Office of Geriatric and Extended Care Operations
GEM	Geriatric Evaluation and Management, a specialized program of Geriatric Evaluation in an inpatient or outpatient setting.
GEMS	VHA Green Environmental Management Systems
GenISIS	Genomic Information System for Integrative Service
GERIPACT	Geriatric Patient-Aligned Care Team
GIS	Geographic Information Systems
GMRA	Government Management Reform Act of 1994
GOE	General Operating Expense
GPO	Government Printing Office
GPRA	Government Performance and Results Act
GPRAMA	Government Performance and Results Act Modernization Act of 2010
GRECC	Geriatric Research, Education and Clinical Centers
GSA	General Services Administration
GSAR	General Services Administration Regulations
GTAS	Government-wide Treasury Account Symbol Adjusted Trial Balance System
HACU	Hispanic Association of Colleges and Universities.
HAI	Health Care-Associated Infections
HAISS	Healthcare Associated Infections and Influenza Surveillance System
HARB	Health Architecture Review Board
HBPC	Home-based Primary Care
HC	Human Capital
HCA	Head of Contracting Activity
HCFAD	Health Care Financial Assurance Division
HCIP	Human Capital Investment Plan
HCR	Health Care Reimbursement (HCR) Department
HCV	hepatitis C
HEC	Health Executive Council
Hey VA	“Hey VA” is a brief message intended for all VA employees, distributed daily through various VA intranet sites, VistA, and VA email networks.
HHS	Department of Health and Human Services
HI	VHA Health Informatics
HIG	Health Information Governance
HIPAA	Health Insurance Portability and Accountability Act of 1996
HISD	Health Information Security Division
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus
HM/HHA	Homemaker/Home Health Aide
HMP	Health Management Platform
HPS	Health Product Support

HQ	Headquarters
HR	Human Resource
HR&A	Human Resources and Administration
HR&SS	Human Resources and Staffing Services
HRC	Health Resource Center
HRC	Human Resources Center
HRGT	Highly Rural Transportation Grants program
HRL	Human Resources Liaison
HRMO	VHA Healthcare Retention and Marketing Office
HRPP	VHA Human Research Protection Programs
HSIPC	VHA Health Systems Innovation Planning and Coordination
HSPD	Homeland Security Presidential Directive
HSPD 12	Homeland Security Presidential Directive 12: Policy for a Common Identification Standard for Federal Employees and Contractors
HSPD 20	Homeland Security Presidential Directive 51: National Continuity Policy.
HSPD 5	Homeland Security Presidential Directive 5: Management of Domestic Incidents
HSPD 7	Homeland Security Presidential Directive 7: Critical Infrastructure Identification, Prioritization, and Protection
HTM	Healthcare Talent Management
HUD	U.S. Department of Housing and Urban Development
IAM	Enterprise Identity and Access Management
IC3	Interagency Care Coordination Committee
ICA	Import Compliance Administrators
ICAM	Identity Credentialing and Access Management
ICARE	VA's Core Values
ICBC	Interagency Care and Benefits Coordination
ICD	ISO Consultation Division
ICD	Intelligence Community Directives
ICD-10	International Classification of Diseases version 10
ICIB	Interagency Clinical Informatics Board
ICS	Internal Controls Service
IDES	Integrated Disability Evaluation System
iEHR	Interoperable Electronic Health Record
IFMVM	Identity Fraud Monitoring, Verification and Mitigation
IG	Inspector General
IGA	Office of Intergovernmental Affairs
IHA	VHA Office of Interagency Health Affairs
IHS	Indian Health Service
IHSC	Immigration and Customs Enforcement Health Service Corps
IOC	Integrated Operations Center
IOM	Integrated Operating Model
IOM	Institute of Medicine
IPERA	Improper Payment Elimination and Recovery ACT
IPO	Interagency Program Office (IPO)
IPT	Integrated Project Teams
IRB	VA Central Institutional Review Board
IRIS	Inquiry Routing and Information System
IRM	Information Resource Management

IRR	Individual Ready Reserve (IRR) Musters Program
ISO	International Organization for Standardization
ISO-9001	A benchmark for quality management
ISP	Interim Staffing Program
ITARS	IT Acquisition Requirements System
ITC	Information Technology Center
ITRM	Information Technology Resource Management
ITSM	IT Service Management
ITSS	Information Technology Support Service
ITWD	IT Workforce Development
IV&V	Independent Verification and Validation
JEC	Joint Executive Council
JIF	Joint Incentive Fund
JSP	Joint Strategic Plan
JV	Joint Ventures
KM&CS	Knowledge Management and Communications Service
KMP	VR&E Knowledge Management Portal
LACS	Logical Access Control Systems
LAPP	Lender Appraisal Processing Program
LETC	Law Enforcement Training Center
LGY	Loan Guaranty Service
LMR	Labor-Management Relations
LNO	Library Network Office
LOT	VHA Learning Organization Transformation
LTSS	Purchased Long Term Services and Supports
LVA	Leadership VA
M21-4	VBA Manpower control and utilization procedural manual
M22-4SAH	VBA Education procedures manual
M28	VBA Vocational Rehabilitation and Employment Procedures Manual
MAC	Medicare Administrative Contractors
MAO	Medical Advisory Opinions
MBM	Meds by Mail
MCAO	Managerial Cost Accounting Office
MCCF	Medical Care and Collections Fund
MFH	Medical Foster Home
MHHI	VHA Mental Health Hiring Initiative
MHS	Mental Health Services
MinX	Management Information Exchange
MIRECC	Mental Illness Education, Research and Clinical Centers
MOCHA	Medication Order Check Healthcare Application.
MOU	Memorandum of Understanding
MOVE!	A program of the National Center for Health Promotion and Disease Prevention
MPR	Monthly Performance Review
MQAS	Management Quality Assurance Service
MRS	VHA Management Review Service
MSC	Military Service Coordinators
MSCOE	Multiple Sclerosis Centers of Excellence
MSN	Memorial Services Network

MSO	Medical Sharing Office
MVI	Master Veteran Index
MVP	Minority Veteran Program Coordinator
MVPC	Minority Veteran Program Coordinator
NAC	Office of National Acquisition Center
NADL	Native American Direct Loan
NAO	National Activations Office
NARA	National Archives and Records Administration
NASDVA	National Association of State Directors of Veterans Affairs
NCA	National Cemetery Administration
NCA CFO	NCA Chief Financial Officer
NCA COS	NCA Chief of Staff
NCA IOC	NCA Integrated Operations Center
NCA OAI	NCA Organizational Assessment and Improvement Program
NCA WO	NCA Watch Officer
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NCP	National Center for Health Promotion and Disease Prevention
NCPIP	National Continuity Policy Implementation Plan
NCPS	National Center for Patient Safety
NCR	National Capitol Region
NCSD	National Communications System Directive
NCVAS	National Center for Veterans Analysis and Statistics
NDAA	National Defense Authorization Act
NDCO	National Data Center Operations
NDMS	National Disaster Medical System
NDS	National Data Systems (NDS): Functions as the central program for managing and tracking all VHA data access requests
NEMA	National Electrical Manufacturers Association
NEPA	National Environmental Policy Act
NFS	Nutrition and Food Services
NFTS	National Finance Training Strategy
NGO	Non-Governmental Organization
NHPA	National Historic Preservation Act of 1966
NHPP	National Health Physics Program
NIDS	National Infectious Diseases Service
NIST	National Institute of Standards and Technology
NLC	National Leadership Council
NLVEC	National Leadership Veteran Experience Committee
NNPO	National Non-VA Medical Care Program Office
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NRC	Nuclear Regulatory Commission
NRF	National Response Framework
NRM	Non-Recurring Maintenance
NRP	VHA National Recruitment Program
NSD	National Service Desk
NSLI	National Service Life Insurance

NSO	National Surgery Office
NSOC	VA Network Security Operations Center
NSPD	National Security Presidential Directive
NSPD 51	National Security Presidential Directive 51: National Continuity Policy.
NTA	VA National IT Training Academy
NVCC	Non-VA Medical Care Coordination
NVCSO	Non-VA Care Support Office
NVSP&SE	National Veterans Sports Programs & Special Events
O2REG	OGC Office of Regulation Policy and Management
OA	VBA Office of Acquisition
OAA	VHA Office of Academic Affiliations
OAEM	Office of Asset Enterprise Management
OAL	Office of Acquisition and Logistics
OALC	Office of Acquisition, Logistics and Construction
OAQ	Office of Acquisition Operations
OBC	Office of Business Continuity
OBO	Office of Business Oversight
OBPI	Office of Business Process Integration
OC	Oleoresin Capsicum (pepper spray)
OCAMES	VHA Office of Capital Asset Management and Engineering
OCFM	Office of Construction, Facilities and Management
OCLA	Office of Congressional and Legislative Affairs
OCR	Optical Character Recognition scanning and verification
OCR	Optical Character Recognition
OCS	Office of Cyber Security
ODA	Office of Disability Assistance
ODI	Office of Diversity and Inclusion
ODNI	Office of the Director of National Intelligence
OEDCA	Office of Employment Discrimination Complaint Adjudication
OEM	Office of Emergency Management
OEO	Office of Economic Opportunity
OERM	Office of Enterprise Risk Management
OESS	Office of Enterprise Support Services
OF	Office of Finance
OFBO	Office of Financial Business Operations
OFO	Office of Field Operations
OFF	Office of Financial Policy
OFPIAR	Office of Financial Process Improvement and Audit Readiness
OFPP	Office of Federal Procurement Policy
OGA	Other Government Agencies
OGC	Office of General Counsel
OHE	VHA Office of Health Equity
OHRA	Office of Human Resource Administration
OHRM	Office of Human Resources Management
OIA	VHA Office of Informatics and Analytics
OICI	OPP - Office of Interagency Collaboration and Integration
OIG	Office of Inspector General
OIS	Office of Information Security

OIT	Office of Information Technology
OLAP	On Line Analytical Processing: An OLAP cube is a multidimensional database that is optimized for data warehouse and online analytical processing applications
OM	VA Office of Management
OMB	Office of Management and Budget
OMGT	VBA Office of Management
OMHO	Office of Mental Health Operations
OMI	Office of the Medical Inspector
OMLA	VHA Office of Medical-Legal Affairs
OMR	Office of Media Relations
ONC	Office of the National Coordinator
OPA	Office of Public Affairs
OPH	VHA Office of Public Health
OPIA	Office of Public and Intergovernmental Affairs
OPM	US Office of Personnel Management
OPR	Interagency Clinical Informatics Board
OPRM	Office of Privacy and Records Management
OPSIM	Office of Personnel Security and Identity Management
ORAA	VHA Office of Regulatory and Administrative Affairs
ORD	Office of Research and Development
ORM	Office of Resolution Management
ORO	Office of Research Oversight
ORR	Department of Health and Human Services (HHS) Office of Refugee Resettlement
OS	Operations Support
OS&LE	Office of Security and Law Enforcement
OSA	VA Office of Survivors Assistance
OSD	Office of the Secretary of Defense
OSD/RA	Office of the Assistant Secretary of Defense for Reserve Affairs
OSDBU	Office of Small and Disadvantaged Business Utilization
OSH	Occupational Safety and Health
OSHA	Occupational Safety and Health Administration
OSI	VHA Office of Strategic Integration
OSP	VA Office of Operations, Security, and Preparedness
OSVA	VA Office of the Secretary
OTGR	VA Office of Tribal Government Relations
OUSH	VHA Office of the Under Secretary for Health
P&F	VBA Pension and Fiduciary
P&LO	Procurement and Logistics Office
P&O WG	The VA/DoD Interagency Care Coordination Committee's Policy and Oversight Work Group.
PA&I	VBA Performance Analysis and Integrity
PACS	Physical Access Control Systems
PACT	VHA Patient-Aligned Care Team
PADRECC	Parkinson's Associated Disorders, Research, Education and Clinical Centers
PAID	Personnel and Accounting Integrated Data system
PAO	Public Affairs Officer
PAR	Performance Accountability Report
PAS	VHA Physician Assistant Services

PAS	Program Application Support Council
PBFS	IT Programming and Budget Formulation Service
PBM	VHA Pharmacy Benefits Management
PBMEPS	Emergency Pharmacy Service
PBO	Pharmacy Benefits Office
PC3	Patient-Centered Community Care
PCCC	Patient-Centered Community Care
PCCCT	Patient-Centered Care and Cultural Transformation
PCD	Purchased Care Division
PcM	Process Management
PCMHI	Primary Care-Mental Health Integration
PCP	Primary Care Physician
PCR	Public Contact Representatives
PCS	Patient Care Services
PCTS	Purchase Card and Travel Service
PD	Product Development
PDAS	Principal Deputy Assistant Secretary
PDHRA	Post-Deployment Health Reassessment Program
PDIC	Post-Deployment Integrated Care
PdM	Product managers
PDUSB	Principal Deputy Under Secretary for Benefits
PDUSH	Principal Deputy Under Secretary for Health
PDUSMA	Principal Deputy Under Secretary for Memorial Affairs
PE	Product Effectiveness program, part of the VHA Health Care Value
PII	Personally Identifiable Information
PIT	Program Integrity Tool that supports detection of fraud, waste, and abuse.
PIT	Point in Time Homeless Count
PIV	Personal Identity Verification
PL	Public Law
PLA	Pharmacy Leadership Academy
PLMS	Pathology and Laboratory Medicine Services
PMAS	Program Management Accountability System
PMC	VBA Pension Management Centers
PMC	NCA Presidential Memorial Certificate Program
PMFP	Presidential Management Fellows Program
PMO	Program Management Office
PMWG	Performance Management Work Group
POI	Program Oversight and Informatics Division
POLARIS	VA OI&T Integrated Calendar
POWER	VHA's Performance and Operations Web-Enabled Reports
PPA	Pollution Prevention Act of 1990
PPACA	Patient Protection and Affordable Care Act
PPBE	VA's Planning, Programming, Budgeting and Execution system
PPD 8	Presidential Policy Directive 8: National Preparedness
PPE	Property Plant and Equipment
PPM	Product and Platform Management
PRE	Pharmacy Re-engineering and Clinical Informatics,
PRPO	Pharmacy Residency Program Office

PRRO	Pharmacy Recruitment and Retention Office
PSHN	Purchased Skilled Home Nursing
PSO	Program Support Operations
PTSD	Posttraumatic Stress Disorder
PVTS	Privacy Verification Tracking System
Q&A	Question and Answer
QCAP	Quality and Corrective Action Plans
QPO	Quality, Performance & Oversight
QSPP	VA Quadrennial Strategic Planning Process
QSV	The Office of the Assistant Deputy Under Secretary (ADUSH) for Quality, Safety and Value
QUERI	VHA Quality Enhancement Research Initiative
R&DC	VHA Research and Development Committee -- Human Research Protection Program
R&R	Review and Resolution (R&R) Department
RAM	OI&T ERM Risk Assessment and Mitigation
RAMS	Research Administrative Management System
RCEP	VHA Research Compliance Education Program
RCO	VHA Research Compliance Officer
RCRA	Resource Conservation and Recovery Act of 1976
RCS	VHA Office of Readjustment Counseling Services
RCV	Records Center and Vault
RERG	Reconstitution Emergency Relocation Group
RFL	Revolving Fund Loan
RISP	VHA Research Information Security Program
RMC	Records Management Center
RMIR	Office of Risk Management and Incident Response
RN	Registered Nurse
RO	Regional Offices
ROFAC	VHA Radiation Oncology Field Advisory Committee
RONA	VA Release of Names and Addresses program.
RRTF	Ruthless Reduction Task Force
RSAP	VHA Research Safety and Animal Welfare
RSD	Review Services Division
RSSP	VHA Research Safety and Security Programs
RVECS	Regional Veteran Employment Coordinators
SAA	State Approving Agencies
SAC	Strategic Acquisition Center
SAPP	Servicer Appraisal Processing Program
SARA	Services Acquisition Reform Act
SB PROGRAM	Spina Bifida Program
SCI/D	Spinal Cord Injury and Disorders
SCIP	Strategic Capital Investment Planning
SCM	Supply Chain Management
SCS	Specialty Care Services
SDWA	Safe Drinking Water Act of 1974
SEA	VA Strategic Environmental Assessment
SECVA	Secretary of Veterans Affairs
SES	Senior Executive Service

SG	Staff Group
SHA	Separation Health Assessments
SHEP	Survey of Health Experiences of Patients
SIC	Security and Investigations Center
SIM	Strategic Investment Management
SIMLEARN	VHA Simulation Learning Education and Research Network
SL	Senior Level employees
SME	Subject Matter Expert
SMI	Serious Mental Illness
SOP	Standard Operating Procedure
SPE	Senior Procurement Executive
SPS	VHA Sterile Processing Services
SSE	Support Services Excellence, one of 5 strategic MyVA priorities
SSGB	VA Support Services Governance Board
STAR	Systematic Technical Accuracy Review
SVH	State Veterans Homes
TAA	Transition Assistance Advisors Program
TAC	Technology Acquisition Center
TAP	Transition Assistance Program
TBI	Traumatic Brain Injury
TDA	Transfer of Disbursing Authority
TEE	Training-Exposure-Experience Tournament
TELE-ICU	Tele-Intensive Care Unit (Tele-ICU) supports the management of critically-ill patients by providing physicians and nurses remote access to other physicians and nurses with critical care expertise.
THP	Tribal Health Programs
TIC	Trusted Internet Connections
TMO	Technology Management Office
TMS	Talent Management System
TPSS	Training Performance Support Systems
TRA	Technical Reference & Assessments
TRB	Technical Review Board
TRICARE	A major part of the Military Health System; TRICARE is the health care program for uniformed service members (active, Guard/Reserve, retired) and their families around the world.
TRM	OneVA Technical Reference Model
TROR	Treasury Report on Receivables
TSGLI	Servicemembers' Group Life Insurance Traumatic Injury Protection
UM	VHA Utilization and Efficiency Management Program
URAC	Utilization Review Accreditation Commission
USAStaffing	U.S. Office of Personnel Management's hiring software solution for Federal agencies.
USB	Under Secretary for Benefits
USC	United States Code
USERRA	Uniformed Services Employment and Reemployment Rights Act
USGLI	United States Government Life Insurance
USH	Under Secretary for Health
USICH	U.S. Interagency Council on Homelessness
USMA	Under Secretary for Memorial Affairs

USSM	Unified Shared Services Management Office
USOC	US Olympic Committee
USVETS	A multidimensional Veteran database
VA NDF	PBM VA National Drug File, an open-source system for drug terminology
VAAA	VA Acquisition Academy
VAAOB	VA Advertising Oversight Board
VAAR	VA Acquisition Regulation
VACO	VA Central Office
VA-ECSIP	VA Enterprise Cybersecurity Strategy & Implementation Plan
VAIOC	VA Integrated Operations Center
VAIQ	Veterans Affairs Internet Quorum
VAKMS	VA Knowledge Management System
VALOR	VA Learning Opportunities Residency
VALU	VA Learning University
VAMC	Veterans Affairs Medical Centers
VAMEDSAFE	A drug safety program with an emphasis on integrated database utilization, communication, and education
Vanguard	VA's national employee magazine
VA-TAMMCS	Vision, Analysis Team, AIM, Map, Measure, Change, Sustain, part of the VHA Systems Redesign and Continuous Improvement program
VATAS	VA Time and Attendance System
VBA FC	VBA Finance Center
VBA/DOD	Veterans Benefits Administration VBA-Department of Defense
VBMS	Veterans Benefits Management System
VCE	VA/DoD Vision Center of Excellence
VCIP	Veterans Claim Intake Program
VCS	Veterans Canteen Service
VDHCBC	Veteran-Directed Home and Community Based Care
VE	Vista Evolution
VEI	Veterans Employment Initiative
VEO	Veterans Experience Office
VEITF	Veterans Employment Initiative Task Force
VERA	Veterans Equitable Resource Allocation model
VERC	Veteran Engineering Resource Centers
VESO	Veteran Employment Services Office
VETSNET	Veterans Service Network - A database that supports Veterans Benefits Administration systems used to administer Veterans benefits.
VHA CEMP	VHA Comprehensive Emergency Management Program
VHA COS	VHA Chief of Staff
VHA DMA	Office of Disability and Medical Assessment
VHA HA	VHA Office of Health Affairs
VHA HEC	VHA Health Eligibility Center
VHA OCLA	VHA Office of Congressional and Legislative Affairs
VHA OSD	VHA Operations and Standardization Department
VHA PIV	VHA Personnel Identity Verification
VHA SPS	National Program Office for Sterile Processing
VHA VOCUS	VHA on-line news media software
VHIC	Veteran Health Identification Card

VISN	Veterans Integrated Service Network
VISTA	A VA imaging system used for the Electronic Health Record
VLER	Virtual Lifetime Electronic Record
VLJ	Veterans Law Judge
VOA	IT Virtual Office of Acquisition
VORS	Veterans Outreach Reporting System
VOW Act	VOW To Hire Heroes Act of 2011
VPN	One-VA Virtual Private Network
VPS	VA Point of Service Program
VR&E	Vocational Rehabilitation and Employment Program
VRC	Vocational Rehabilitation Counselor
VR&E	Vocational Rehabilitation and Employment
VRI	Veterans' Reopened Insurance
VRM	Veterans Relationship Management
VSLI	Veterans' Special Life Insurance
VSO	Veterans Service Organization
VSOC	VetSuccess on Campus
VSSC	VISN (Veterans Integrated Service Network) Support Services Center
VTs	Veterans Transportation Program
W2W	Warriors to Workforce, an intern program to train and educate wounded Veterans
WC	Workers Compensation
WHOFBNP	White House Office of Faith-Based and Neighborhood Partnerships
WM	Workforce Management Branch
WMC	VHA Workforce Management and Consulting
YRRP	DoD Yellow Ribbon Reintegration Program

Appendix B: Organization Charts -- Alternate Representations

Purpose

This appendix provides an alternate representation of each organization chart and figure in the document, for those who may be accessing it using a screen reader. Each section below lists the corresponding figure, and provides a list of organizations and sub organizations depicted in each organization chart. Indentations are used to represent the hierarchical relationships among organizations and sub organizations. For the other illustrations in the document, this section provides a short description of the graphic and its purpose. Each section provides a hyperlink to the corresponding figure.

Figure 1: Department of Veterans Affairs

[Click here to go to Figure 1](#)

- ❖ Secretary
 - Chief of Staff
 - Deputy Secretary
 - Inspector General
 - General Counsel
 - Board of Veterans' Appeals
 - Acquisition, Logistics, and Construction
 - Office of Enterprise Support Services
 - Chief Veterans Experience Officer
 - Veterans Benefits Administration
 - Veterans Health Administration
 - National Cemetery Administration
 - Assistant Secretary for Congressional and Legislative Affairs
 - Assistant Secretary for Information and Technology
 - Assistant Secretary for Enterprise Integration
 - Assistant Secretary for Management
 - Assistant Secretary for Human Resources and Administration
 - Assistant Secretary for Public and Intergovernmental Affairs
 - Assistant Secretary for Operations, Security and Preparedness

Figure 2: Office of the Secretary of Veterans Affairs

[Click here to go to Figure 2](#)

- ❖ Secretary of Veterans Affairs
- ❖ Deputy Secretary of Veterans Affairs
 - Office of Employment Discrimination Complaint Adjudication
 - Office of Small and Disadvantaged Business Utilization
 - Senior Advisor to the Secretary
 - Senior Advisor to the Deputy Secretary
 - Chief Technology Officer

- Chief of Staff
 - Deputy Chief of Staff
 - Executive Secretariat
 - Office of Mission Operations
 - Office of Protocol
 - Office of Administrative Operations
 - White House Liaison
 - Office of Strategic Engagement
 - Veterans Service Organization Liaison
 - Office of Client Relations
 - Center for Strategic Partnerships
 - Center for Women Veterans
 - Center for Minority Veterans
 - Advisory Committee Management Office
 - Center for Faith-Based and Neighborhood Partnerships
 - Office of Survivors Assistance
 - Office of Regulatory Policy and Management
 - Speechwriters

Figure 3: Office of the Inspector General

[Click here to go to Figure 3](#)

- ❖ Inspector General
- ❖ Deputy Inspector General
 - Special Assistant to the Inspector General
 - Congressional Relations
 - Counselor to the Inspector General
 - ◆ Office of Contract Review
 - ◆ Release of Information Office
 - Chief of Staff Healthcare Oversight Integration
 - Assistant Inspector General Investigations
 - ◆ Deputy Assistant Inspector General Investigations – HQ Operations
 - ◆ Deputy Assistant Inspector General Investigations – Field Operations
 - Assistant Inspector General Audits and Evaluations
 - ◆ Deputy Assistant Inspector General Audits and Evaluations – HQ Operations
 - ◆ Deputy Assistant Inspector General Audits and Evaluations – Field Operations
 - Assistant Inspector General Management and Administration
 - ◆ Deputy Assistant Inspector General
 - Assistant Inspector General Healthcare Inspections
 - ◆ Deputy Assistant Inspector General Healthcare Inspections (Medical Consultation and Review)
 - ◆ Deputy Assistant Inspector General Healthcare Inspections (Operations)

Figure 4: Board of Veterans Appeals[Click here to go to Figure 4](#)

- ❖ Chairman
 - Vice Chairman
 - Principal Deputy Vice Chairman Appellate Group
 - Chief Counsel for Policy and Procedure
 - Chief Counsel for Operations
 - Director for Management, Planning, and Analysis
 - Deputy Vice Chairman (1)
 - Deputy Vice Chairman (2)
 - Chief Veterans Law Judge (1)
 - Chief Veterans Law Judge (2)
 - Chief Veterans Law Judge (3)
 - Chief Veterans Law Judge (4)
 - Chief Veterans Law Judge (5)
 - Chief Veterans Law Judge (6)
 - Chief Veterans Law Judge (7)
 - Chief Veterans Law Judge (8)
 - Chief Veterans Law Judge (9)
 - Chief Veterans Law Judge (10)

Figure 5: Office of General Counsel[Click here to go to Figure 5](#)

- ❖ General Counsel
 - Executive Director, Management, Planning and Analysis
 - Deputy General Counsel (Legal Operations and Accountability)
 - North Atlantic District (North)
 - North Atlantic District (South)
 - Midwest District (East)
 - Midwest District (West)
 - Pacific District (North)
 - Pacific District (South)
 - Southeast District (North)¹
 - Southeast District (South)
 - Continental District (East)
 - Continental District (West)
 - Loan Guaranty National Practice Group
 - Collections National Practice Group
 - Torts Law Group

¹ Chief Counsel, Southeast District (North) also serves as the Designated Agency Ethics Official.

- Personnel Law Group
- Office of Accountability Review
- Deputy General Counsel (Legal Policy)
 - Benefits Law Group
 - Health Care Law Group
 - Veterans Claims Litigation Law Group
- Information Law Group
- Real Property Law Group
- Procurement Law Group
- District Contracting National Practice Group
- Administrative Law Group
- Counselors to the General Counsel

Figure 6: Map of States within VA Districts

[Click here to go to Figure 6](#)

There are five administrative districts in VA: North Atlantic, Southeast, Continental, Midwest, and Pacific. The Office of General Counsel has subdivided each of these into two sub districts. Figure 6 shows a map of the United States, subdivided into Districts, sub Districts, and States. Here are the Districts and the States belonging to each:

North Atlantic North:	Delaware
	Maine
	Massachusetts
	New Hampshire
	New Jersey
	New York
	Pennsylvania
	Rhode Island
	Vermont
North Atlantic South:	Maryland
	North Carolina
	Virginia
	West Virginia
Southeast North	Alabama
	Georgia
	Kentucky
	South Carolina
	Tennessee
Southeast South	Florida
Continental East	Arkansas
	Louisiana
	Mississippi
Continental West	Colorado

	Montana
	Oklahoma
	Texas
	Utah
	Wyoming
Midwest West	Illinois
	Iowa
	Kansas
	Minnesota
	Missouri
	Nebraska
	North Dakota
	South Dakota
	Wisconsin
Midwest East	Indiana
	Michigan
	Ohio
Pacific North	Alaska
	California (north)
	Hawaii
	Idaho
	Nevada
	Oregon
	Washington
Pacific South	Arizona
	California (south)
	New Mexico

Figure 7: Office of Acquisition, Logistics, and Construction

[Click here to go to Figure 7](#)

Principal Executive Director, Office of Acquisition, Logistics, and Construction

- Deputy Assistant Secretary, Office of Acquisition and Logistics
- Executive Director, Office of Acquisition Operations
- Executive Director, Office of Construction and Facilities Management

Figure 8: Office of Acquisition and Logistics

[Click here to go to Figure 8](#)

- Deputy Assistant Secretary, Office of Acquisition and Logistics
 - Associate Deputy Assistant Secretary, Office of Acquisition Program Support
 - Office of Business Services
 - Office of CFO, Supply Fund

-
- Office of Acquisition Human Capital Management Services
- Office of Acquisition Systems Integration
 - Associate Deputy Assistant Secretary, Office of Policy Systems and Oversight
- Office of Procurement Policy and Warrant Management Services
- Office of Enterprise Acquisition System Services
- Office of Risk Management and Compliance Services
 - Associate Deputy Assistant Secretary, Office of Logistics and Supply Chain Management
- Office of Logistics Policy and Supply Chain Management
- Office of Logistics Support Services
 - Associate Deputy Assistant Secretary, Office of National Healthcare Acquisition
- Office of Business Resource Services
- Office of Federal Supply Services
- Office of National Contract Services
- Office of Denver Acquisition and Logistics Center
 - Chancellor, VA Acquisition Academy
- Vice Chancellor, Acquisition Internship
- Vice Chancellor, Facilities Management School
- Vice Chancellor, Supply Chain Management School
- Vice Chancellor, Contracting Professional School
- Vice Chancellor, Program Management School
- Learning Standards Office

Figure 9: Office of Acquisition Operations

[Click here to go to Figure 9](#)

- ❖ Executive Director, Office of Acquisition Operations
 - Senior Acquisition Technical Advisor
 - Associate Executive Director, Technology Acquisition Center (TAC)
 - TAC Procurement Service A
 - TAC Procurement Service B
 - TAC Procurement Service C
 - TAC Procurement Service D
 - TAC Procurement Service E
 - TAC Operations Service
 - TAC Program Advisory Service
 - TAC Acquisition Rapid Response Team
 - TAC Austin
 - Associate Executive Director, Strategic Acquisition Center (SAC)
 - SAC Procurement Services A
 - SAC Procurement Services B
 - SAC Procurement Services C

- SAC Program Advisory Service
- SAC Acquisition Rapid Response Team
- SAC Operations Service
- SAC Compliance Service
- SAC Frederick
- Director, Customer Advocacy Service
- Director, Acquisition Business Service (ABS)
 - ABS Simplified Acquisition Procurement Division
 - ABS Operations Review Division

Figure 10: Office of Construction and Facilities Management

[Click here to go to Figure 10](#)

- ❖ Executive Director, Office of Construction and Facilities Management
 - Associate Executive Director, Office of Operations
 - Office of Operations – National Region
 - Office of Operations – Eastern Region
 - Office of Operations – Central Region
 - Office of Operations – Western Region
 - Office of Operations – Real Property Service
 - Associate Executive Director, Office of Facilities Planning
 - Facilities Planning Development Service
 - Facilities Standards Service
 - Cost Estimating Service
 - Associate Executive Director, Office of Resource Management
 - Financial Management Service
 - Database Management and Logistics Service
 - HR and Training Service
 - Associate Executive Director, Office of Facilities Acquisition
 - AE Construction Contracting Policy
 - Acquisition Support National Region
 - Acquisition Support Eastern Region
 - Acquisition Support Central Region
 - Acquisition Support Western Region
 - Real Property Service
 - Associate Executive Director, Office of Programs and Plans
 - Project Control Service
 - Quality Assurance Service
 - Consulting Support Service

Figure 11: Veterans Benefits Administration

[Click here to go to Figure 11](#)

- ❖ Under Secretary for Benefits
- ❖ Principal Deputy Under Secretary for Benefits
 - Director, Office of Strategic Planning
 - Office of Business Process Integration
 - Veterans Benefits Management System Program Office
 - Veterans Relationship Management Program Office
 - Deputy Under Secretary for Disability Assistance
 - Compensation Service
 - Pension and Fiduciary Service
 - Insurance Service
 - Benefits Assistance Service
 - Deputy Under Secretary for Economic Opportunity
 - Education Service
 - Loan Guaranty Service
 - Vocational Rehabilitation and Employment Service
 - Office of Transition, Employment, and Economic Impact
 - Deputy Under Secretary for Field Operations
 - North Atlantic District Office
 - Southeast District Office
 - Midwest District Office
 - Records Management Center
 - Pacific District Office
 - Continental District Office
 - Appeals Management Center
 - National Work Queue
- ❖ Chief of Staff
- ❖ Deputy Chief of Staff
 - Office of Management
 - Office of Human Resources
 - Office of Facilities and Administration
 - Office of Employee Development and Training
 - Office of Employee Engagement, Diversity, and Inclusion
 - Office of Acquisition
 - Office of Resource Management
 - Administrative and Loan Accounting Center
 - Hines Finance Center
 - Office of Performance, Analysis and Integrity
 - Executive Review
 - Congressional Affairs
 - Corporate Communications
 - Communications and Case Management

Figure 12: Veterans Health Administration

[Click here to go to Figure 12](#)

❖ Under Secretary for Health

- Readjustment Counseling Service
- Office of Research Oversight
- Nursing
- Chief of Staff
- Deputy Chief of Staff
 - Executive Correspondence
 - Communications
 - Congressional/Legislative Affairs
 - Regulatory and Administrative Affairs
 - National Leadership Council
 - Client Relations

❖ Principal Deputy Under Secretary for Health

- Assistant Deputy Under Secretary for Health for Workforce Services
 - Workforce Management and Consulting
 - Employee Education System
 - National Center for Organization Development
 - Academic Affiliations
 - Finance
 - Strategic Integration
- Deputy Under Secretary for Health Policy and Services
 - Assistant Deputy Under Secretary for Health for Policy and Planning
 - Assistant Deputy Under Secretary for Health for Patient Care Services
 - Assistant Deputy Under Secretary for Health for Informatics and Information Governance
 - Interagency Health Affairs
 - Research and Development
 - Connected Health and Telehealth
- Deputy Under Secretary for Health for Operations and Management
 - Assistant Deputy Under Secretary for Health for Administrative Operations
 - Emergency Management
 - Procurement and Logistics
 - Capital Asset Management and Engineering
 - Veterans Canteen Service
 - Environmental Programs
 - Occupational Safety, Health and GEMS Programs
 - Healthcare Technology Management
 - Engineering and Occupational Safety & Health
 - Assistant Deputy Under Secretary for Health for Clinical Operations
 - Homelessness
 - Surgical Services
 - Primary Care Operations
 - Geriatrics and Extended Care Operations
 - Mental Health Operations
 - Sterile Processing Services
 - Dentistry
 - Disability and Medical Assessment

- Spinal Cord Injury and Disorders Operations
 - Access and Clinical Administration
- Patient-Centered Care and Cultural Transformation
- Network Support
- Veterans integrated Service Networks (VISN)
- Deputy Under Secretary for Health for Organizational Excellence
 - Chief Improvement Officer
 - Health Equity
 - Assistant Deputy Under Secretary for Health for Integrity
 - Office of the Medical Inspector²
 - Compliance and Business Integrity
 - Internal Audits and Risk Assessment
 - Management Review Service
 - Ethics in Healthcare
 - Assistant Deputy Under Secretary for Health for Quality, Safety and Value
 - Quality Standards and Programs
 - Safety and Risk Awareness
 - Health Equity
 - Healthcare Value
 - High Reliability Systems and Consultation
 - Analytics and Business Intelligence
- Deputy Under Secretary for Health for Community Care
 - Provider Engagement and Services
 - Clinical Program Management
 - Decision support and Reporting
 - Operations/Chief Business Office
 - Membership and Health Benefits
 - Care Coordination

Figure 13: National Cemetery Administration

[Click here to go to Figure 13](#)

- ❖ Under Secretary for Memorial Affairs
- ❖ Principal Deputy Under Secretary for Memorial Affairs
 - Veterans Cemetery Grant Program
 - Alternative Dispute Resolution and Diversity
 - Chief of Staff
 - Deputy Under Secretary for Field Programs
 - District Offices
 - National Cemeteries

² The Medical Inspector has a dashed-line relationship to the Principal Deputy Under Secretary for Health.

- Office of Field Programs
 - Scheduling and Eligibility Office
 - Policy, Planning, and Communications
 - Current and Integrated Operations
 - Emergency Preparedness
- Memorial Programs Service
 - Operations
 - Program Support
 - Presidential Memorial Certificates
 - Applicant Assistance
 - Centralized Processing Appeals
 - MPS Processing Sites
 - First Notice of Death
 - Cemetery Development and Improvement Service
- ❖ Deputy Under Secretary for Finance and Planning
 - Legislative and Regulatory Service
 - Policy and Planning Service
 - Budget Service
 - Capital and Performance Budgeting
 - Budget Operations and Field Support
 - Finance Service
 - Accounting Operations Division
 - Accountability Division
 - Business Process Improvement and Compliance Service
- ❖ Deputy Under Secretary for Management
 - Human Capital Management
 - Training and Workforce Development and Safety
 - Human Resources Center – Indianapolis, IN
 - Policy and Programs
 - Information Management and Business Support Service
 - Business Transformation, Sustainment and Requirements Service
 - Management and Communication Service
 - History
 - Executive Correspondence
 - Communications and Outreach Support
 - Contracting Service
 - Contracting – Stafford, Virginia
 - Contracting – Washington, D.C.
 - Design and Construction Service

Figure 14: High Level Overview of the Office of Management

[Click here to go to Figure 14](#)

- ❖ Office of Management
 - Office of Budget
 - Office of Asset Enterprise Management

- Office of Finance
- Office of Programming, Analysis, and Evaluation

Figure 15: Office of Management – Detailed Overview

[Click here to go to Figure 15](#)

- ❖ Assistant Secretary for Management and Chief Financial Officer
- ❖ Principal Deputy Assistant Secretary
 - Deputy Assistant Secretary for Budget
 - Assistant Deputy Assistant Secretary for Budget
 - Director, Office of Asset Enterprise Management
 - Capital Operations and Program Service
 - Capital Asset Policy, Planning and Strategic Service
 - Investment and Enterprise Development Service
 - Capital Asset Management Service
 - Green Management Program Service
 - Deputy Assistant Secretary for Finance
 - Office of Financial Business Operations
 - Office of Financial Process Improvement and Audit Readiness
 - Office of Financial Policy
 - Improper Payments Remediation and Oversight Office
 - Office of Internal Controls
 - Debt Management Center
 - Financial Services Center
 - Director, Office of Corporate Analysis and Evaluation
 - Programming Service
 - Analysis and Evaluation Service

Figure 16: Overview of the Office of Budget

[Click here to go to Figure 16](#)

- ❖ Assistant Secretary for Management and Chief Financial Officer
- ❖ Principal Deputy Assistant Secretary
 - Deputy Assistant Secretary for Budget
 - Assistant Deputy Assistant Secretary for Budget
 - Director, Medical Programs
 - Director, Benefits Programs
 - Director, Management Programs
 - Director, Budget Process and Data Management
 - Director, IT Programs

Figure 17: Office of Asset Enterprise Management[Click here to go to Figure 17](#)

- ❖ Assistant Secretary for Management and Chief Financial Officer
- ❖ Principal Deputy Assistant Secretary
 - Director, Office of Asset Enterprise Management
 - Capital Operations and Program Service
 - Capital Asset Policy, Planning, and Strategic Service
 - Investment and Enterprise Development Service
 - Capital Asset Management Service
 - Green Management Program Service

Figure 18: Office of Finance[Click here to go to Figure 18](#)

- ❖ Assistant Secretary for Management and Chief Financial Officer
- ❖ Principal Deputy Assistant Secretary
- ❖ Deputy Assistant Secretary for Finance
 - Office of Financial Business Operations
 - Financial Management Transformation Service
 - Financial Management System Service
 - Business Intelligence and Analytics Service
 - Office of Financial Process Improvement and Audit Readiness
 - Financial Process Improvement and Audit Readiness Service
 - Office of Financial Policy
 - Accounting Policy Office
 - Grants Management Service
 - Management and Financial Reports Service
 - Improper Payments Remediation and Oversight Office
 - Office of Internal Controls
 - Internal Controls Program Management Office
 - Internal Controls Over Operations Office
 - Internal Controls Over Financial Reporting Office
 - Debt Management Center
 - Operations Directorate
 - Strategic Management and Special Operations Directorate
 - Financial Services Center – Austin, Texas
 - Corporate Travel and Reporting Office
 - Financial Accounting Service
 - Financial Healthcare Service
 - Financial Operations Service
 - Financial Payroll Service
 - Financial Support Service
 - Information Technology Service

- Purchase Card and Travel Service

Figure 19: Office of Programming, Analysis, and Evaluation

[Click here to go to Figure 19](#)

❖ Director, Programming, Analysis, and Evaluation Service

- Director, Programming Service
- Director, Analysis and Evaluation Service

Figure 20: Office of Information and Technology

[Click here to go to Figure 20](#)

❖ Assistant Secretary and Chief Information Officer

- VA Chief Technology Officer
- Chief of Staff
- Deputy Director, VA/DoD Interagency Program Office
- Principal Deputy Assistant Secretary and Deputy Chief Information Officer
- Deputy Chief Information Officer, Privacy and Risk
 - Executive Director, Privacy
 - Executive Director, Quality and Compliance
- Deputy Assistant Secretary, Service Delivery and Engineering
 - Field Operations
 - Systems Engineering
 - Enterprise Operations
- Deputy Chief Information Officer Enterprise Data Management
 - Health Data Management
- Deputy Chief Information Officer, Architecture, Strategy, and Design
 - Chief Architecture
- Chief Financial Officer, Technology Resource Management
 - Budget and Finance
 - Chief Learning Officer
- Deputy Chief Information Officer, Account Manager Corporate
- Deputy Chief Information Officer, Account Manager Health
 - Customer Engagement
 - Customer Engagement
 - Customer Engagement
- Deputy Chief Information Officer, Account Manager Benefits
 - Customer Engagement
 - IT Knowledge Management
 - Customer Engagement
- Deputy Chief Information Officer, Chief Information Security Officer
 - Cyber Security Strategy
 - Field Security Service

- Security Operations
- Deputy Assistant Secretary, Enterprise Program Management Office
 - Application Support
 - Enterprise Project Management
 - Application Management
 - Lean Systems Engineering
- Deputy Chief Information Officer, Strategic Sourcing
 - Acquisition Strategy Vendor Relationship

Figure 21: Office of Enterprise Integration

[Click here to go to Figure 21](#)

- ❖ Assistant Secretary Office of Enterprise Integration
 - Principal Deputy Assistant Secretary
- ❖ Office of Planning and Performance Management
 - Strategic Foresight and Risk Management
 - Strategic Planning
 - Integrated Enterprise Planning
 - Performance Management
- ❖ Office of Data Governance and Analytics
 - Statistics and Analytics
 - Predictive Analytics and Actuary
 - Data Governance and Management
- ❖ Office of Policy and Interagency Collaboration
 - Interagency Collaboration
 - Integrated Disability Evaluation System
 - Policy Management and Analysis
- ❖ Office of Performance Improvement
- ❖ VA Center for Innovations
- ❖ Office of Transformation (MyVA)

Figure 22: Office of Operations, Security, and Preparedness

[Click here to go to Figure 22](#)

- ❖ Assistant Secretary for Operations, Security and Preparedness
- ❖ Principal Deputy Assistant Secretary
 - Special Assistant
 - Staff Assistant
- ❖ Deputy Assistant Secretary for Emergency Management and Resilience
 - Planning, Exercise, Training and Evaluation (PETE)
 - Operations and National Security Service (O&NSS)
 - VA Integrated Operations Center (VAIOC)
- ❖ Director for Office of Personnel Security and Identity Management
 - HSPD-12 Program

- Identity Credential and Access Management (ICAM)
- Personnel Security and Suitability (PSS)
- Security Investigations Center (SIC)
- ❖ Director for Office of Resource Management
 - Human Resources Management
 - Administrative and Logistics Management
 - Financial Management and Budget
 - Support Services
- ❖ Director for Office of Security and Law Enforcement
 - Police Service
 - Police Oversight and Investigations
 - Infrastructure Protection
 - Executive Protection
 - Intelligence and Analysis
 - Law Enforcement and Training Center
 - Academic Program
 - Technical Program
 - Advanced Academic Program
 - Training Standards Program

Figure 23: Office of Human Resources and Administration

[Click here to go to Figure 23](#)

- ❖ Assistant Secretary for Human Resources and Administration
 - Corporate Senior Executive Management Office
- ❖ Principal Deputy Assistant Secretary
 - Operations Support Staff*
 - Office of Administration
 - Office of Diversity and Inclusion (ODI)
 - Office of Human Resources and Management (OHRM)
 - Office of Labor Management Relations (OLMR)
 - Office of Resolution Management (ORM)
 - VA Learning University (VALU)
 - Veteran Employment Services Office (VESO)

* Operations Support Staff Functions: Budget and Risk Management; Program Management/Acquisition Support; MyVA Integration; HR&A Communications; Strategic Planning and Organizational Performance

Figure 24: Office of Administration

[Click here to go to Figure 24](#)

- ❖ Office of Administration
 - Occupational Safety and Health

- Transit Benefits
- Space and Renovations
- Facilities
- Support
- Performance Improvement and Accountability

Figure 25: Office of Diversity and Inclusion

[Click here to go to Figure 25](#)

- ❖ Office of Diversity and Inclusion
 - Workforce Analysis
 - Outreach and Retention
 - Training and Communications
 - Employee Engagement

Figure 26: Office of Human Resources Management

[Click here to go to Figure 26](#)

- ❖ Office of Human Resources Management
 - HR Policy Advisor
 - Business Operations and Oversight
 - HR Policy and Planning
 - HR Automation, Systems and Analytics

Figure 27: Office of Labor-Management Relations

[Click here to go to Figure 27](#)

- ❖ Office of Labor-Management Relations
 - HR Staff Office
 - Training and Intervention
 - Executive Office

Figure 28: Office of Resolution Management

[Click here to go to Figure 28](#)

- ❖ Office of Resolution Management
 - Region 1
 - Region 2
 - Region 3
 - Business Operations
 - Management Services

- Anti-Harassment

Figure 29: VA Learning University

[Click here to go to Figure 29](#)

- ❖ VA Learning University
 - Leadership Development
 - Career and Employee Development
 - Program Accountability and Risk Management
 - Learning Infrastructure
 - Business Office
 - Budget and Travel

Figure 30: Veteran Employment Services Office

[Click here to go to Figure 30](#)

- ❖ Veteran Employment Services Office
 - Field Operations
 - Human Resources Services
 - Resource and Data Management
 - Strategic Communications

Figure 31: Corporate Senior Executive Management Office

[Click here to go to Figure 31](#)

- ❖ Corporate Senior Executive Management Office
 - Strategic Program Management and Support
 - Executive Development and Outreach
 - Policy and Programs
 - Recruitment and Operations

Figure 32: Office of Public and Intergovernmental Affairs

[Click here to go to Figure 32](#)

- ❖ Assistant Secretary for Public and Intergovernmental Affairs
- ❖ Principal Deputy Assistant Secretary
 - Chief of Staff
 - Special Assistant
 - Executive Director Office of Public Affairs
 - Senior Advisor
 - Director, Digital Media Engagement

- Director, Field Operations
- Press Secretary
 - Deputy Press Secretary
- Director, Media Relations
- Executive Director, Corporate Communications
 - Director, Office of Internal Communications
 - Director, National Veterans Outreach Office
 - Director, Homeless Veterans Outreach and Strategic Communications
- Deputy Assistant Secretary, Office of Intergovernmental Affairs
 - Director, Office of State and Local Government
 - Director, Office of Tribal Government Relations

Figure 33: Office of Congressional and Legislative Affairs

[Click here to go to Figure 33](#)

- ❖ Assistant Secretary for Congressional and Legislative Affairs
 - Director, Operations and Administration
 - Principal Deputy Assistant Secretary
 - Deputy Assistant Secretary for Congressional Affairs
 - Oversight
 - Benefits Legislative Affairs Service
 - Corporate Enterprise Legislative Affairs Service
 - Health Legislative Affairs Service
 - Legislative Affairs
 - Outreach
 - Congressional Liaison Service

Figure 34: Chief Veterans Experience Office

[Click here to go to Figure 34](#)

- ❖ Chief Veterans Experience Officer
 - Deputy Chief Veterans Experience Officer
 - Chief of Staff
 - Director, Management, Planning and Analysis
 - Insight and Design
 - Enterprise Measurement and Performance Improvement
 - Enterprise Veteran Operations
 - Community Engagement
 - North Atlantic District Veterans Experience Office
 - Southeast District Veterans Experience Office
 - Midwest District Veterans Experience Office
 - Continental District Veterans Experience Office
 - Pacific District Veterans Experience Office

Figure 35: Office of Enterprise Support Services

[Click here to go to Figure 35](#)

- ❖ Principal Executive Director, Enterprise Support Services
 - Deputy Director
 - Chief of Staff
 - Chief Administrative Officer
 - Chief Financial Officer
 - Director, Program Management
 - Director, Customer Experience
 - Director, Franchise Fund Oversight
 - Deputy Director
 - Director, Record and Vault Enterprise Centers
 - RCV Budget and Program Office
 - RCV Operations Division
- ❖ Director, Human Resources
 - Enterprise HR Programs
 - Enterprise Training Delivery

